STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chris Ragan,

Petitioner,

vs. No. 10WC005322

Continental Tire North America,

14IWCC0191

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both parties herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, the necessity of medical treatment, temporary disability, permanent disability and "credit," and being advised of the facts and law, modifies the decision of the Arbitrator as stated below, and otherwise affirms and adopts the decision of the Arbitrator which is attached hereto and made a part hereof.

FACTS

At the May 3, 2012, arbitration hearing, Petitioner testified that his job as a truck tire builder requires a significant amount of reaching, pulling and throwing. Petitioner also testified that he uses his left arm for overhead lifting more often than he uses his right arm because of the way that his workstation is set up. Petitioner's job description shows that a truck tire builder must perform medium to heavy work, must have full range of motion in both arms and must "lift 50 or more pounds on an occasional to frequent basis."

A pre-accident report of operation shows that on April 12, 2007, Dr. Paletta performed a left shoulder diagnostic arthroscopy, debridement of a posterosuperior labral tear, subacromial

decompression and bursectomy with acromioplasty. Petitioner testified that he received a settlement award for 25 percent loss of use of the left arm for the prior work injury associated with the 2007 surgery. Petitioner also testified that after being released from Dr. Paletta's care following the 2007 surgery, he was not pain-free but his left shoulder symptoms improved and were nothing like what he had experienced prior to the surgery.

On January 29, 2010, Petitioner felt increased pain in his left shoulder while building tires for Respondent. That day, Petitioner completed a statement of events and an injury report, stating that he injured his left shoulder, along with his elbows, while performing repetitive motion job duties. On February 8, 2010, Petitioner treated at the health services department located in Respondent's plant and continued to complain of left shoulder pain. Petitioner reported that his left shoulder bothered him more at work and was referred to Work Fit for physical therapy. Medical records from Work Fit show that Petitioner underwent physical therapy for his left shoulder in February and March of 2010.

In his April 23, 2010, report, Dr. Paletta noted that he treated Petitioner for a left shoulder superior labrum from anterior to posterior (SLAP) tear approximately three years before and performed surgery in April of 2007. Dr. Paletta also noted: "[Petitioner] did quite well and was returned to full work and continued to do well until about December or January of this year when he began to note the onset of some left shoulder pain and tightness." On examination, Petitioner had positive left shoulder impingement signs. Dr. Paletta reviewed left shoulder x-rays that showed a normal bony anatomy and no significant degenerative changes. Dr. Paletta diagnosed Petitioner with left shoulder impingement syndrome, noted that there was no evidence of a recurrent SLAP tear, and recommended that Petitioner undergo a subacromial injection and return to full duty work.

On May 26, 2010, Petitioner treated with Dr. Stiver and reported that his left shoulder symptoms began on January 29, 2010, due to "[w]ork repetitive motion." Petitioner also reported that his left shoulder achiness was different from the symptoms associated with his previous SLAP tear. Dr. Stiver examined Petitioner and noted that he had a mildly positive Grind's test and crepitance. Dr. Stiver noted that Petitioner either had possible irritation from a prior labral repair or impingement syndrome, and recommended a left shoulder MRI. The July 9, 2010, left shoulder MRI showed increased signal within the supraspinatus tendon which was compatible with tendinopathy, an intact rotator cuff, a possible previous surgery at the acromioclavicular joint, and a normal glenoid labrum and biceps labral complex.

On July 16, 2010, Petitioner returned to Dr. Stiver who noted that the MRI showed "what looks to be like impingement with spurring." Dr. Stiver opined that Petitioner would require an arthroscopic subacromial decompression at some point and noted that Petitioner wanted to have surgery for his left shoulder after he had surgery for his elbows. On August 24, 2010, Petitioner underwent surgery for his right elbow; and on September 17, 2010, Petitioner underwent surgery for his left elbow. Subsequently, Petitioner underwent physical therapy and returned to full duty work on November 22, 2010. Petitioner testified that while he was off work for his bilateral elbow condition, his left shoulder symptoms did not improve.

On March 14, 2011, Dr. Stiver generated a letter to Petitioner's attorney and opined:

> "Chris Ragan's job activities performed as a truck tire builder have aggravated his left shoulder and necessitating [sic] arthroscopic subacromial decompression on his left shoulder as outlined last summer. He had a SLAP repair approximately 3 years ago in 2007 and had done well until he was starting to do the tire repair activities with lifting and started having more pain, crepitus, and grating. As a result he has developed spurring with impingement symptoms on the left shoulder necessitating the subacromial decompression. This is directly work related."

During Dr. Lehman's May 24, 2011, section 12 examination, Petitioner had significant complaints of pain in his left shoulder, tenderness in the area of the AC joint, a "Hawkins test [that] seem[ed] to be positive subjectively," pain with full forward flexion and internal rotation, and a negative Lidocaine stress test. Dr. Lehman opined that Petitioner's work activities did not cause or aggravate Petitioner's left shoulder condition, and stated:

> "I do not believe there is any objective evidence that there is pathology in his left shoulder. The patient had a negative MRI in terms of impingement processes and had a negative Lidocaine challenge test. It would be my opinion based on reviewing the medical records that the patient has no significant pathology in his shoulder other than tendinopathy, which is a long term process and is a degenerative process. There appears to be 1) no rotator cuff tear and 2) there appears to be no objective impingement syndrome and lastly, when we injected the subacromial space his pain did not improve. The medical literature clearly states that with a negative Lidocaine challenge the chances for resolution of shoulder pain arthroscopically with a subacromial decompression are greatly decreased. Based on this, I do not believe that the patient requires further care and treatment of his left shoulder and again, there appears to be no definitive diagnosis on his exam and MRI. This patient does not in fact have impingement syndrome."

On August 8, 2011, Dr. Stiver performed a left shoulder subacromial decompression and found "a lot of bursal tissue" in the subacromial space. Dr. Stiver last treated Petitioner on October 12, 2011, and noted that Petitioner was doing well except for a "twinge in the upper part of his shoulder when he just twists or turns it a certain way." Dr. Stiver noted that Petitioner had good strength, prescribed a Medrol Dosepak and Prednisone for about two to three weeks, and recommended that Petitioner follow up in four weeks unless he was asymptomatic. Petitioner was off work from August 8, 2011, through October 30, 2011.

At his January 13, 2012, deposition, Dr. Stiver opined that Petitioner's MRI showed inflammation of the supraspinatus, one of the rotator cuff muscles, as well as swelling within the tendon. Dr. Stiver noted that impingement syndrome is an irritation of the supraspinatus tendon. On cross-examination, Dr. Stiver noted that during Petitioner's left shoulder surgery, he found thickened or inflamed bursal tissue, which covers the supraspinatus tendon. Dr. Stiver opined

that the inflamed bursal tissue caused Petitioner's symptoms. Dr. Stiver also opined that Petitioner's left shoulder MRI showed soft tissue impingement and spurring underneath the acromion, and that spurring has "got to be huge to see on a plain x-ray." Lastly, Dr. Stiver opined that Petitioner's condition would not have improved when he stopped performing repetitive activities if he had already developed bursal tissue in the left shoulder. Dr. Stiver noted that on October 12, 2011, Petitioner had no functional loss in his left shoulder.

At his March 29, 2012, deposition, Dr. Lehman opined that x-rays will show "a substantial subacromial spur" if present, and the x-rays that he performed at the time of the section 12 examination showed no evidence of subacromial spurring. Dr. Lehman also opined that a Lidocaine stress test is when Lidocaine is injected into the subacromial space to see whether the place that is injected is the source of the symptoms. On cross-examination, Dr. Lehman agreed that supraspinatus tendinopathy can cause pain.

DISCUSSION

The Arbitrator found that Petitioner did not sustain a work-related repetitive trauma injury to his left shoulder that manifested on January 29, 2010. The Commission disagrees.

The Commission finds that Dr. Paletta's opinions are credible and persuasive as he performed Petitioner's April 2007 left shoulder surgery and had first-hand knowledge of Petitioner's left shoulder condition during that time. In his report, Dr. Paletta noted that Petitioner "did quite well" after undergoing the 2007 surgery for a SLAP tear, and "was returned to full work and continued to do well until about December or January of [2010] when he began to note the onset of some left shoulder pain and tightness." This is consistent with Petitioner's testimony that his left shoulder symptoms improved and were nothing like what he had experienced prior to the 2007 surgery. In addition, the Commission finds that Dr. Stiver's opinions are more persuasive than Dr. Lehman's opinions. The July 9, 2010, left shoulder MRI showed increased signal within the supraspinatus tendon, which was compatible with tendinopathy. Dr. Stiver opined that impingement syndrome is an irritation of the supraspinatus tendon, and the MRI showed inflammation and swelling of the supraspinatus tendon, which is evidence of impingement syndrome. In apparent agreement with each other, Dr. Stiver opined that spurring has "got to be huge to see on a plain x-ray," and Dr. Lehman testified that x-rays will show "a substantial subacromial spur." The Commission notes that both Dr. Paletta and Dr. Stiver diagnosed Petitioner with left shoulder impingement syndrome.

The Commission finds that Petitioner's left shoulder SLAP tear resolved after the 2007 surgery and Petitioner returned to full duty work until January 29, 2010, when his repetitive trauma injuries to the elbows and left shoulder manifested. The Commission awards all medical expenses related to Petitioner's left shoulder condition, in addition to the medical expenses the Arbitrator awarded for treatment related to Petitioner's bilateral elbow condition. The Commission also awards Petitioner additional temporary total disability benefits from August 8, 2011, through October 30, 2011.

With respect to the nature and extent of Petitioner's left shoulder disability, Petitioner testified that after Dr. Stiver performed the left shoulder surgery, the constant tightness he had experienced prior to the surgery improved. Currently, Petitioner's left shoulder tires more easily and it is more difficult to perform his work duties and overhead activities than it was prior to the surgery. Additionally, Petitioner's left shoulder aches when he lies down on his left side, and he experiences some left shoulder weakness. At his deposition, Dr. Stiver testified that as of October 12, 2011, Petitioner had no functional loss in his left shoulder. The Commission finds that Petitioner's left shoulder injury caused the loss of use of 7.5 percent of the person-as-a-whole pursuant to section 8(d)(2).

In regards to Petitioner's permanency award for a prior left arm injury, the Commission finds that Respondent is not entitled to credit. In *Killian v. The Industrial Comm'n*, 148 Ill. App. 3d 975, 500 N.E.2d 450 (1st Dist. 1986), the appellate court denied an employer credit under section 8(e)(17) of the Act for a prior permanent partial disability award made to a claimant for an injury to the back. Thereafter, the claimant reinjured his back two times. As a result of the subsequent back injuries, the Commission found that the claimant sustained a loss to the person-as-a-whole under section 8(d)(2), and found that the employer was entitled to credit for the prior permanency award. On appeal, the appellate court found that the employer was not entitled to credit for the prior permanency award; reasoning that an employer can receive a credit for previously paid benefits only when an employee has reinjured a body part or member listed in section 8(e), and the "back" is not listed as a "member" under section 8(e). In addition, the appellate court held that "credits should be interpreted narrowly and should not be extended by implication." *Killian*, 148 Ill. App. 3d at 979.

In the instant case, Petitioner received a permanency award for a prior left shoulder injury under section 8(e)(10). Subsequently, the appellate court held that permanency awards for shoulder injuries must be awarded under section 8(d)(2), instead of as a scheduled loss to the arm under section 8(e). *Will County Forest Preserve District v. Workers' Compensation Comm'n,* 970 N.E.2d 16, 25 (3d Dist. 2012). In accordance with *Will County*, the Commission has awarded Petitioner permanent partial disability benefits under section 8(d)(2) for his left shoulder injury, which is the subject of the instant case. The Commission finds that Respondent is not entitled to credit for the prior left shoulder injury as an employer can receive a credit for previously paid benefits only when an employee has reinjured a body part or member listed in section 8(e), and the "shoulder" is not a "member" under section 8(e). The Commission declines to extend the concept of credit to the interpretation of section 8(d)(2) in accordance with *Killian.*

Lastly, the Commission affirms the Arbitrator's award of medical expenses, temporary total disability benefits and permanent partial disability benefits with respect to Petitioner's compensable repetitive trauma injuries to the right and left elbows.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed on November 1, 2012, is hereby modified as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner all reasonable and necessary medical expenses for treatment related to Petitioner's left shoulder and bilateral elbow conditions under §8(a) and §8.2 of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $564.70 per week for 21-6/7 weeks, from August 24, 2010, through October 31, 2010, and from August 8, 2011, through October 30, 2011, which are the periods of temporary total disability for which compensation is payable.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $508.23 per week for a period of 37.5 weeks, as provided in §8(d)2 of the Act, because the injuries sustained caused permanent partial disability equivalent to 7.5 percent loss of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $508.23 per week for a period of 82.23 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused permanent partial disability equivalent to 15% loss of use of the left arm and 17.5% loss of use of the right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $43,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 18 2014
MJB/db
o-01/28/14
52

Michael J. Brennan

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RAGAN, CHRIS
Employee/Petitioner

Case# **10WC005322**

CONTINENTAL TIRE NORTH AMERICA INC
Employer/Respondent

14IWCC0191

On 11/1/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.16% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1459 LEVENHAGEN LAW FIRM PC
T FRITZ LEVENHAGEN
4495 N ILLINOIS ST SUITE E
BELLEVILLE, IL 62226

0299 KEEFE & DEPAULI PC
JAMES K KEEFE JR
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FAIRVIEW HTS, IL 62208

0693 FEIRICH MAGER GREEN & RYAN
KEVIN L MECHLER
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CARBONDALE, IL 62903

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Chris Ragan
Employee/Petitioner

v.

Continental Tire North America, Inc.
Employer/Respondent

Case # 10 WC 05322

Consolidated cases: _____

14IWCC0191

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **May 3, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent with respect to the shoulder only?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury to the shoulder only?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary related to the testing and treatment of the shoulder? Has Respondent paid all appropriate charges for all reasonable and necessary medical services for the shoulder only?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

14IWCC0191

FINDINGS

On **January 29, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment as to the Petitioner's left shoulder.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being as to his shoulder ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$34,923.95**; the average weekly wage was **$847.05**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **2** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$4,194.91** for TTD, $ for TPD, $ for maintenance, and **$4,180.00** for non occupational indemnity disability benefits and $11,181.06 in other benefits.

Respondent is entitled to a credit for any money previously paid with respect to this claim under Section 8(j) of the Act.

ORDER

The Respondent shall pay the Petitioner Temporary Total Disability benefits from August 24, 2010 through October 31, 2010.

The Respondent shall pay the Petitioner $508.23 / week for 37.95 weeks as the Petitioner sustained a 15% loss of the use of the left arm.

The Respondent shall pay the Petitioner $508.23 / week for 44.28 weeks as the Petitioner has sustained a loss of 17.5% of the right arm.

The Petitioner is not awarded the medical bills for the left shoulder with total balances of $12,845.69 because the testing and treatment for the left shoulder was not reasonable, necessary or causally related to his work activities.

The Petitioner is not awarded any PPD benefits for the shoulder as the Petitioner failed to prove that the condition arose out of and in the course of his employment.

The Respondent is entitled to credit for amounts paid by work comp for the elbows and group for the left shoulder.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Deborah L. Simpson
Signature of Arbitrator

Oct. 31, 2012
Date

NOV - 1 2012

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chris Ragan,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 10 WC 05322**
	)	
Continental Tire North America,	)	
	)	
Respondent.	)	**14IWCC0191**
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on January 29, 2010, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They further agree that the Petitioner gave the Respondent notice of the accident within the time limits stated in the Act, that the Petitioner sustained accidental injuries or was last exposed to an occupational disease that arose out of and in the course of employment as to his elbows only, and petitioner's current condition of ill-being is causally connected to this injury or exposure as to his elbows only. Finally, the parties agree that the petitioner is entitled to TTD from 8/24/10 through 10/13/10.

At issue in this hearing is as follows: (1) did the Petitioner sustain accidental injuries on January 29, 2010 to his left shoulder that arose out of and in the course of his employment with the Respondent; (2) is the Petitioner's current condition of ill being with respect to his left shoulder causally connected to this injury or exposure; (3) is the Respondent liable for the unpaid medical bills contained in Petitioner's Exhibit number 1 with respect to testing and treating the Petitioner's left shoulder; (4) Is the Petitioner entitled to TTD from 10/14/10 through 10/31/10 and 08/08/11 through 10/30/11; and (5) the nature and extent of the injury.

STATEMENT OF FACTS

The Petitioner is employed by the Respondent as a truck tire builder. He has worked for the Respondent in that position since January of 1992. The Petitioner alleges that he sustained injuries to both of his elbows and to his left shoulder as a result of his repetitive work activities working for the Respondent as a truck tire builder. As to the bilateral elbow condition the only issues in dispute between the Petitioner and Respondent are the claim for TTD benefits from October 14, through October 31, 2010, and the nature and extent of the injury. The Respondent disputes all issues regarding the left shoulder.

The Petitioner testified that his job duties as a truck tire builder are described in a job description attached to Dr. Beatty's medical records which he wrote out for the doctor. (P. Ex. 3) He stated that he is required to repetitively push and pull on sidewall books, shoulder pad books, bead books, and ply-up cassettes. As part of his job he is required to scrape out inner liners on the tires. While building truck tires, he is required to meet a rate of 150 tires per shift. He throws tire tread weighing 30 - 60 pounds on a tread tray and performs repetitive lifting at or above shoulder level. He testified that the way that the machine is set up at his work station he uses his left arm more for overhead lifting than his right arm. He is required to use hand and power tools including a zip stitcher, hand stitchers, rubber knifes and a paint brush. (P. Ex. 3). He testified that the job description he provided to Dr. Beatty and the job description attached to the deposition of Dr. Lehman (marked as P. Ex. 4) accurately describes some of the job duties that he was required to perform as a truck tire builder leading up to his injury of January 29, 2010.

The Petitioner testified that on January 29, 2010, he was performing his regular job duties as a truck tire builder and while he was building a tire his arms and elbows got very painful. As he was lifting, he felt increased pain in both of his elbows and his left shoulder. He knew that he was going to need medical treatment so he reported the injury to his supervisor. When he reported the injury to his employer a written Injury/Incident/Illness Report had to be prepared and signed by the Petitioner's supervisor. This was done on January 29, 2010.

On January 29, 2010, the Petitioner was sent to Health Services at the plant. The doctor at Health Services told the Petitioner to wear wrist splints and referred him to Work-Fit, the onsite physical therapy facility. The Petitioner testified that he had physical therapy for his left shoulder at Work Fit. The records reflect that the Petitioner was not able to attend physical therapy before or after work due to child care issues, he was allowed to attend physical therapy on work time. (P. Ex. 2)

On March 18, 2010, petitioner saw Michael Beatty, M.D. for the treatment of his bilateral elbow symptoms. Dr. Beatty noted that petitioner was a truck tire builder who noticed fifth finger numbness over the past few months. Dr. Beatty's examination found a positive Tinel's at the bilateral cubital tunnels. Dr. Beatty recommended nerve testing. Dr. Beatty also reviewed the petitioner's handwritten job description and in his letter of March 25, 2010, to T.Fritz Levenhagen, Esq. he wrote "...it would be my opinion with the knowledge of his work activity as a truck tire builder that that activity would be the causative basis for the development of the cubital tunnel problems involving the ulnar nerve." (P. Ex. 3)

The Petitioner returned to Health Services and saw Dr. Byler who issued a prescription for physical therapy which was performed at Hamilton Memorial Hospital. The Petitioner received physical therapy for both his elbows and his left shoulder at Hamilton Memorial Hospital. (P. Ex. 9) The Petitioner testified that he had difficulties with tenderness on his left shoulder and that the therapist had to adjust his therapy when using a warm pack on it. The pressure of the warm pack caused the Petitioner increased pain.

Dr. Beatty ordered nerve conduction studies that were performed on April 1, 2010 by Dr. Edward Trudeau. The testing was consistent with bilateral cubital tunnel syndrome. (P. Ex 4).

The nerve conduction studies confirmed Dr. Beatty's diagnosis of bilateral cubital tunnel syndrome. There was no current evidence of cervical radiculopathy or brachial plexopathy or mononeuritis in the left shoulder. The Dr. Trudeau thought that perhaps it was too early or too mild to document electrodiagnostically at that point in time. (P. Ex. 4, report page 5 of 8) Based upon the nerve conduction studies, Dr. Beatty recommended bilateral cubital tunnel releases. (P. Ex. 3).

On April 23, 2010, the Respondent sent the Petitioner to be examined by George A. Paletta, Jr., M.D. at the Orthopedic Center of St. Louis. According to Dr. Paletta's report the petitioner complained of bilateral elbow pain and numbness and tingling in the fourth and fifth fingers. Dr. Paletta found positive impingement signs in the left shoulder and positive ulnar nerve compression tests and positive Tinel's sign at the elbows. Dr. Paletta reviewed the nerve studies and shoulder x-rays. Dr. Paletta diagnosed impingement syndrome of the left shoulder and bilateral cubital tunnel syndrome, left greater than right. Dr. Paletta recommended an injection into the left shoulder and surgical intervention for the elbows. In his report, Dr. Paletta states "In my opinion, his ulnar neuropathy or cubital tunnel syndrome is causally related to the repetitive nature of his work requirements." (R. Ex. 8)

The Petitioner had previously undergone a left shoulder surgery with Dr. Paletta on April 12, 2007, that consisted of repair of a labral tear, subacromial decompression, bursectomy and acromioplasty. (R. Ex. 7) The Petitioner received an award for 25% loss of use of the left arm for that injury and surgery. (R. Ex 10). The Petitioner testified that the shoulder symptoms improved but never totally resolved from the 2007 surgery.

On May 26, 2010, petitioner saw Phillip Stiver, M.D. in Evansville, Indiana for treatment of his left shoulder symptoms. Dr. Stiver noted that petitioner underwent a prior SLAP repair in 2007 and recently began having achiness in the left shoulder area. On examination, Dr. Stiver found crepitance and a positive Grind's test. Dr. Stiver's impression was possible irritation from the prior labral repair or impingement syndrome. He ordered a left shoulder MRI scan. The Petitioner was allowed to return to work full duty with no restrictions. (P. Ex. 6, deposition exhibit #2 attached).

On July 9, 2010, an MRI of the left shoulder was performed at St. Mary's Medical Center in Evansville, Indiana. According to the report of the radiologist, findings were consistent with supraspinatus tendinopathy. (P. Ex. 6, deposition exhibit #2 attached)

On July 16, 2010, Dr. Stiver reviewed the results of the MRI scan with the Petitioner. Dr. Stiver found impingement and spurring on the MRI scan and recommended surgical intervention. The Petitioner was permitted to work pending approval of worker's compensation for the surgery. Worker's compensation denied the surgery. (P. Ex. 6, deposition exhibit #2 attached)

On August 24, 2010, Dr. Beatty performed a release of the ulnar compressive neuropathy at the right elbow at Anderson Hospital. According to the operative report, Dr. Beatty identified the ulnar nerve proximal to the medial epicondyle and found it to be covered by an intermuscular band that was released. Dr. Beatty then proceeded to identify the nerve at its entry point at the

medial epicondyle and visualized a very tight musculofascial banding in that area which was released. Dr. Beatty relieved compression from the ulnar nerve well into the forearm. Dr. Beatty took Petitioner off work as of August 24, 2010. (P. Ex. 3)

On September 17, 2010, Dr. Beatty performed a release of the ulnar compressive neuropathy at the left elbow at Anderson Hospital. According to the operative report, an incision was made and Dr. Beatty approached proximal to the medial epicondyle where he had to incise through an area of overlying intermuscular band to uncover, identify, and demonstrate the ulnar nerve proximal. Dr. Beatty felt this could account for compression of the nerve. Just distal to the medial epicondyle, Dr. Beatty found a thick fascial muscular attachment that was incised and released the nerve. (P. Ex. 3)

On September 24, 2010 the Petitioner saw Dr. Beatty for follow-up after his surgery. The sutures were removed from the left elbow and he was given permission to begin physical therapy on his right elbow. He was instructed to return in four weeks. (P. Ex. 3)

On October 12, 2010, respondent sent petitioner for a Section 12 examination with David Brown, M.D. Dr. Brown recommended that petitioner continue with supervised therapy and return to work with restrictions. Dr. Brown opined that the Petitioner could return to work with full use of his right arm and with about a five to ten pound lifting limit with the left upper extremity. It was further stated that he could return to full duty with no restrictions in four to five weeks. (R. Ex. 2)

On October 25, 2010 the Petitioner saw his Dr. Beatty for follow-up at which time he was given permission to return to work limited duty for two weeks with the plan being he would progress to full duty in two weeks. (P. Ex. 3) The Petitioner testified that he chose to continue to remain off from work at the recommendation of his treating surgeon, Dr. Beatty. Petitioner remained off from work at Dr. Beatty's recommendation continuously from August 24, 2010 until October 31, 2010.

On November 10, 2010, the Petitioner reported by telephone to Dr. Beatty that he was still experiencing discomfort on the limited duty and would like to continue on limited duty for another week before returning to full duty. Dr. Beatty agreed and wrote a slip ordering one more week of restricted duty, return to full duty on November 22, 2010. (P. Ex. 3)

On March 14, 2011, Dr. Stiver wrote a letter to T. Fritz Levenhagen, attorney at law. In that letter he wrote that the spurring and impingement that the Petitioner suffered in his left shoulder was in his opinion directly related to the Petitioner's work duties. (P. Ex. 6, deposition exhibit 2 attached)

On May 24, 2011, petitioner saw Richard Lehman, M.D. pursuant to Section 12 of the Act. Dr. Lehman did not find any objection evidence of pathology in petitioner's left shoulder and stated that he did not believe that petitioner's work activities aggravated his left shoulder. He stated, and testified at his deposition that the treatment that the Petitioner had received to date, including the excellent x-rays that were taken at Dr. Lehman's office were reasonable and necessary. He opined that the Petitioner did not need any other treatment for his left shoulder.

(R. Ex. 9, pp. 18-25, plus R. deposition exhibit #2 attached) Dr. Lehman opined further that Dr. Paletta was seeking to treat the subjective complaints of the Petitioner rather than the objective findings, which were that there was no impingement or degeneration and there has to be objective findings before doctors treat with invasive techniques such as injections. (R. Ex. 9 pp. 23-26)

On July 20, 2011 petitioner returned to Dr. Stiver with complaints of continuing achiness, crepitance, and grating the left shoulder. Dr. Stiver renewed his recommendation for surgical intervention and the procedure was scheduled. The Petitioner indicated he would go through his private insurance and worry about worker's compensation in the future. (P. Ex. 6, deposition exhibit #2 attached)

On August 8, 2011, Dr. Stiver performed a left shoulder arthroscopic subacromial decompression at St. Mary's Surgicare in Evansville, Indiana. The Petitioner remained off from work at the recommendation of Dr. Stiver from August 8, 2011 until October 30, 2011 after the surgery. (P. Ex. 6, deposition exhibit #2 attached) The Petitioner attended physical therapy at Hamilton Memorial Hospital for his left shoulder condition. (P. Ex. 9)

The Petitioner last saw Dr. Stiver on October 12, 2011 at which time he was prescribed a Medrol Dosepak. (P. Ex. 6, deposition exhibit #2 attached)

The Petitioner took Dr. Stiver's deposition on January 13, 2012. At that time Dr. Stiver testified that he diagnosed the Petitioner with impingement syndrome, which is really an irritation of the supraspinatus tendon, based upon his review of the July 9, 2010, MRI and clinical examination. (P. Ex. 6 p. 10). He recommended surgery that would involve shaving off the undersurface of the acromion to remove any spurring. (P. Ex. 6 pp. 10-11). Dr. Stiver then testified that he performed the subacromial decompression on August 8, 2011. (P. Ex. 6 pp. 11-12). Dr. Stiver opined, based upon Petitioner's job description that required a lot of lifting, pushing, pulling and use of the arm at shoulder height or above that the job activities as a tire builder were a cause in the condition and the need for surgery. (P. Ex. 6 pp. 15-16).

On cross examination, Dr. Stiver admitted that the x-rays he performed at his office of the Petitioner's left shoulder were normal. (P. Ex. 6 p. 29). He admitted that the radiologist did not report any soft tissue spurring on the July 9, 2010, left shoulder MRI. (P. Ex. 6 pp. 30-31). He also acknowledged that if a relationship existed between the jobs duties and left shoulder symptoms then if Petitioner refrained from those activities he would expect the symptoms to improve. (P. Ex. 6 pp. 33-34). Dr. Stiver admitted that as of October 12, 2011, there was no functional loss in the left shoulder as a result of the surgery. (P. Ex. 6 p. 36).

The Respondent took the deposition of Dr. Richard Lehman on March 29, 2012. Dr. Lehman testified that the x-rays performed at his office showed normal spacing at the AC joint with no evidence of subacromial spurring or AC joint arthritis. (R. Ex. 9 p. 9). He testified that x-rays would pick up any substantial subacromial spur or loss of distance between the acromial humeral space. (R. Ex. 9 pp. 9-10). He testified that upon his physical examination of the Petitioner that there was no objective evidence of impingement syndrome. (R. Ex. 9 p. 10). He also explained that the lidocaine stress test was negative and that the test is used to determine the

source of the patients' symptoms or pathology. (R. Ex. 9 pp.10-11). Dr. Lehman opined within a reasonable degree of medical certainty that because he could not identify any pathology in Petitioner's left shoulder that he did not require any additional testing or treatment for the pain that the Petitioner was experiencing. (R. Ex. 9 pp. 11-12).

Dr. Lehman reviewed the operative report and medical records from Dr. Stiver. After doing so, he stated that in his opinion the surgery was neither reasonable nor necessary. (R. Ex. 9 pp. 13-14). Dr. Lehman testified that the typical treatment regimen for subacromial bursitis is anti-inflammatory medication followed by physical therapy which in 85-90% of the cases improves the condition. (R. Ex. 9 p. 15). If those methods fail, then cortisone injections are typically offered before surgery. (R. Ex. 9 p. 15). Finally, Dr. Lehman opined that the complaints in Petitioner's left shoulder would not be related to his job duties at Respondent. (R. Ex. 9 p. 15).

The Petitioner testified that he has been fully released by Dr. Stiver and has no further appointments. The Petitioner testified that he remained off from work at the recommendation of Dr. Beatty from August 24, 2010 through October 31, 2010. He testified that, similar to when he was placed on light duty and undergoing physical therapy, during the time he was off of work for the two surgeries his symptoms with respect to his left shoulder did not improve. The Petitioner further testified that he was paid his temporary total disability benefits from August 24, 2010 until October 14, 2010.

Following his left shoulder surgery, the Petitioner remained off from work at the recommendation of Dr. Stiver from August 8, 2011 through October 30, 2011. During the time that he remained off from work for his left shoulder condition, he received gross Accident & Health Benefits in the amount of $4,180.00.

The Petitioner testified that the medical bills admitted into evidence at arbitration as Petitioner's Exhibit #1 pertain to the treatment that he received for his left shoulder injury. Petitioner testified that the treatments he received improved his symptoms. The Petitioner testified that although he has had improvement with his elbows, he continues to have aching discomfort at a level of a 2 on a scale of 1 to 10. He testified that he especially has pain in his elbows when stitching tires, throwing tread and bead dumping. This discomfort he experiences increases with activities.

The Petitioner testified that he also experiences increased discomfort during cold weather. Petitioner testified that he has difficulty holding a power washer when he washes his car because of elbow discomfort. He constantly switches hands, his arms ache and tire easy. The Petitioner feels that he has loss of strength in his elbows and has difficulty picking up and holding his 5-year old daughter for any period of time due to his loss of strength and the fact that his arms tire easily; he cannot play sports with his son like catch or baseball.

The Petitioner further testified that his elbows wake him up at night. Some nights he will only sleep three to four hours at a time. His elbows wake him up with tingling. He still takes Tylenol once a day because of his elbow symptoms. He testified that his elbow pain comes and goes and that some days his discomfort is worse than others.

With regard to his left shoulder, the Petitioner testified that the shoulder surgery performed by Dr. Stiver improved his symptoms and that before the surgery his shoulder was tight and the tightness was constant even when he was performing light duty. He testified that he has lost strength in his shoulder since his injury and that he has difficulty sleeping on his left side because of shoulder discomfort. He has difficulty with overhead activities in using his left arm and shoulder. He has difficulty playing sports with his son and especially shooting a basketball because of his left shoulder condition. He mentioned that he had difficulty pushing and pulling on cassettes and picking up and loading the KUK using his left shoulder. He has definitely noticed a loss of strength in his left shoulder.

The Petitioner acknowledged that light duty was offered to him at the time that Dr. Brown released him to light duty. Petitioner testified that he decided to remain off from work at the recommendation of his treating surgeon rather than attempt to return to a light duty position. However, the petitioner did not believe that the light duty position would have caused him any physical harm.

CONCLUSIONS OF LAW

An injury is accidental within the meaning of the Worker's Compensation Act when it is traceable to a definite time, place and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v Industrial Board,* 284 Ill. 378, 120 N.E. 2d 249, 251 (1918) If the condition or injury is not shown to be traceable to a definite time, place and cause and no evidence shows that the work activity caused the physical condition, compensation will be denied. *Johnson v. Industrial Commission,* 89 Ill.2d 438, 433 N.E.2d 649, 60 Ill.Dec. 607 (1982)

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,* 58 Ill. 2d 226, 317 N.E.2d 515 (1974) "Arising out of" is primarily concerned with the causal connection to the employment. The majority of cases look for facts that establish or demonstrate an increased risk to which the employee is subjected to by the situation as compared to the risk that the general public is exposed to.

We therefore hold that the date of an accidental injury in a repetitive trauma compensation case is the date on which the injury "manifests itself." Manifests itself means the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person. *Peoria County Belwood Nursing Home vs Industrial Commission,* 115 Ill.2d 524, 505 N.E.2d 1026, 1029, 106 Ill.Dec. 235 (1987)

In cases relying on the repetitive trauma concept, the claimant generally relies on medical testimony to establish a causal connection between the claimant's work and the claimed

disability. See *Peoria County Bellwood*, 115 Ill.2d 524 (1987); *Quaker Oats Co. v. Industrial Commission*, 414 Ill. 326 (1953)

The burden is on the party seeking the award to prove by a preponderance of credible evidence the elements of the claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Hannibal, Inc. v. Industrial Commission*, 38 Ill.2d 473, 231 N.E.2d 409, 410 (1967)

Accidental injury need not be the sole causative factor, or even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Rock Road Construction Co. v. Industrial Commission*, 37 Ill.2d 123, 227 N.E.2d 65 (1967)

Did the Petitioner sustain accidental injuries on January 29, 2010 to his left shoulder that arose out of and in the course of his employment with the Respondent? Is the Petitioner's current condition of ill being with respect to his left shoulder causally connected to this injury or exposure?

These two questions are closely related and the evidence for both of them is the same so they will be discussed together.

Both Dr. Paletta and Dr. Stiver initially diagnosed the Petitioner with left shoulder impingement, Dr. Stiver admitted on cross examination that the x-rays did not support that diagnosis. Dr. Lehman, examining the Petitioner and reviewing the same x-rays did not find that the Petitioner had left shoulder impingement syndrome. Petitioner did not prove that he sustained an injury to his shoulder on January 29, 2010.

While Dr. Paletta and Dr. Stiver diagnosed left shoulder impingement syndrome in 2010, the Petitioner did not prove that the condition is causally related to his job activities. This conclusion is based primarily upon the Petitioner's testimony that even though he felt the pain started with his job activities, he testified that the condition worsened when he was initially placed on light duty and worsened again when he was off work nearly two months for the bilateral elbow surgeries.

The Petitioner's testimony confirms the opinions of Dr. Stiver and Dr. Lehman that if an activity is responsible for a condition and the activity is removed then the condition should improve. Here, Petitioner unequivocally stated the condition did not improve when the work activities were removed by placing him on restricted duty and later when he was off of work for the two elbow surgeries. Further, Petitioner testified that prior to January 29, 2010, he still experienced left shoulder problems with overhead activities away from work.

The Petitioner did not prove that he sustained an accidental injury involving left shoulder impingement syndrome and did not prove that the condition is causally related to his work activities for Respondent.

Is the Respondent liable for the unpaid medical bills contained in Petitioner's Exhibit number 1 with respect to testing and treating the Petitioner's left shoulder?

There was no objective evidence to support the diagnosis of impingement syndrome for surgery. There were no objective tests establishing that the Petitioner had any impingement in his shoulder before the surgery on May 24, 2011. Dr. Lehman was the last physician to examine the Petitioner before surgery on May 24, 2011. He testified that based upon the examination and the negative lidocaine test there was no evidence of impingement syndrome. The examination was consistent with the x-rays from all three physicians that did not show any spurring consistent with impingement syndrome.

The Petitioner did not attempt any conservative treatments prior to surgery when at least an injection was offered. Dr. Paletta, who performed Petitioner's left shoulder surgery in 2007, felt medications and an injection were a reasonable course of treatment for the Petitioner's left shoulder. Dr. Lehman testified that the typical course for impingement syndrome is medications, physical therapy and then injections before undergoing surgery. Other than the physical therapy in early 2010 when the Petitioner first complained of the pain and which was stopped at the Petitioner's request the Petitioner did not attempt any other conservative treatments.

The Petitioner did not prove that the left shoulder surgery performed by Dr. Stiver on August 8, 2011, was reasonable and necessary

Is the Petitioner entitled to TTD from 10/14/10 through 10/31/10 and 08/08/11 through 10/30/11?

The Petitioner has undergone two surgeries for the injuries to his elbows which arose out of and in the course of his employment and were related to his current condition of ill being. His treating physician took the Petitioner off of work beginning on August 24, 2010 with the first elbow surgery and kept him off of work from that date until after the second surgery which occurred on September 17, 2010. The Petitioner was released by his treating physician to return to work light duty beginning on October 31, 2010. He was permitted to return to work full duty on November 22, 2010. The Petitioner is entitled to TTD from October 14, 2010 through October 31, 2010.

The Respondent offered light duty based upon the determination of Dr. Lehman that the Petitioner could return to work and the Petitioner refused the light duty. However, it was Dr. Lehman's opinion that the Petitioner could have returned on October 14, 2010, but as Dr. Lehman pointed out in his report after the Section 12 examination, he is not the treating physician.

The Petitioner is not entitled to TTD for the time that he was off between August 8, 2011 and October 31, 2011 for the shoulder surgery.

The Respondent shall pay temporary total disability benefits to the Petitioner for the time period between October 14, 2010 and October 31, 2010, the additional time that the treating physician kept the Petitioner off of work. The Respondent shall have a credit for all temporary

total disability benefits previously paid and shall receive a credit for $4,180.00 in accrued non-occupational disability benefits paid.

What is the nature and extent of the injury?

As a result of the injuries sustained on January 29, 2010, the petitioner sustained 15% permanent partial disability of the left arm and a 17.5% permanent partial disability of the right arm based upon the diagnosis and treatment of the Petitioner's cubital tunnel.

ORDER OF THE ARBITRATOR

The Respondent shall pay the Petitioner Temporary Total Disability benefits from August 24, 2010 through October 31, 2010.

The Respondent shall pay the Petitioner $508.23 / week for 37.95 weeks as the Petitioner sustained a 15% loss of the use of the left arm.

The Respondent shall pay the Petitioner $508.23 / week for 44.28 weeks as the Petitioner has sustained a loss of 17.5% of the right arm.

The Petitioner is not awarded the medical bills for the left shoulder with total balances of $12,845.69 because the testing and treatment for the left shoulder was not reasonable, necessary or causally related to his work activities.

The Petitioner is not awarded any PPD benefits for the shoulder as the Petitioner failed to prove that the condition arose out of and in the course of his employment.

The Respondent is entitled to credit for amounts paid by work comp for the elbows and group for the left shoulder.

Deborah L. Simpson
Signature of Arbitrator

Oct 31, 2012
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tommy Oliver,

Petitioner,

vs.

No. 11WC028718

Rausch Construction Company Inc.,

14IWCC0192

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant to an order of remand from the Circuit Court of Cook County. In accordance with the order of the circuit court entered on June 27, 2013, the Commission considers the issues of penalties pursuant to sections 19(k) and 19(l), and attorney fees pursuant to section 16 of the Illinois Workers' Compensation Act, and being advised of the facts and law, finds that Petitioner is not entitled to penalties or attorney fees as stated below.

On July 28, 2011, Petitioner filed an Application for Adjustment of Claim, alleging that on July 20, 2011, he sustained injuries to his body as a whole while working for Respondent. Subsequently, Petitioner amended the application to allege that the work accident occurred on July 19, 2011.

On October 3, 2011, Petitioner filed a petition for penalties pursuant to sections 19(l) and 19(k) and attorney fees pursuant to section 16, claiming that Respondent had not paid temporary total disability benefits or Petitioner's medical bills. On October 4, 2011, Respondent filed a

response asserting that it had subpoenaed Petitioner's medical records and informed Petitioner's attorney of its need for additional records to determine compensability. In her decision, the Arbitrator made no specific findings with respect to penalties and attorney fees; however, she awarded section 19(l) penalties in the sum of $4,230.00, section 19(k) penalties in the sum of $17,011.59 and section 16 attorney fees in the sum of $6,804.64.

On review, Respondent argued that the Arbitrator erred by awarding penalties and fees. Respondent maintained that Petitioner's failure to report a work injury on the alleged date of accident was a reasonable basis for challenging liability. Respondent relied on the testimony of Patrick Kutzer, Respondent's site superintendant and Petitioner's supervisor on July 19, 2011, who testified that Petitioner did not appear to be in pain and did not report an accident on that date. Petitioner did not inform Mr. Kutzer of his reported work injury until July 25, 2011. Respondent posited that Petitioner could have sustained a right elbow injury between July 19, 2011, and July 25, 2011.

In response, Petitioner contended that Respondent's failure to pay temporary total disability benefits and medical bills was unreasonable, vexatious and solely for the purpose of delay as the medical records fully supported Petitioner's claim. The fact that Petitioner reported the accident six days after it occurred does not create a reasonable basis for Respondent's failure to pay benefits as Petitioner credibly testified that his right elbow condition worsened after he went home on July 19, 2011.

On November 26, 2012, the Commission issued a Decision and Opinion on Review and found that:

> "penalties pursuant to sections 19(k) and 19(l), and attorney fees pursuant to section 16 should not be imposed against Respondent in the present case. Respondent's conduct in the defense of this claim was neither unreasonable nor vexatious as **there were legitimate issues in dispute with respect to accident and causal connection, such as Petitioner's failure to report a work accident on his last day of work, Petitioner's request to fill out an accident report six days after the reported work injury and Mr. Kutzer's testimony**." (Emphasis added).

Petitioner appealed to the Circuit Court of Cook County.

On June 27, 2013, the circuit court issued an order on appeal, stating:

> "This matter is remanded to the Illinois Workers' Compensation Commission for further findings of fact regarding the Commission's decision regarding penalties and attorneys fees. If testimony has not been taken on this issue, then such testimony should be heard. If facts have already been presented on this then the Commission needs to reduce its inferences to findings of fact."

In compliance with the circuit court's order, the Commission expands on the reasons why it found Petitioner ineligible for penalties and attorney fees as stated in its November 26, 2012, Decision and Opinion on Review. The Commission denies Petitioner's request for penalties pursuant to sections 19(k) and 19(l) and attorney fees pursuant to section 16 based on the following: (1) although Petitioner alleged he injured his right elbow on his last day of work, he failed to report he had sustained a work accident that day; (2) Petitioner sought medical treatment and requested to complete an accident report six days after the reported work injury; and (3) Mr. Kutzer, Petitioner's supervisor on the day of the accident, testified that Petitioner did not appear to be in pain and did not report an accident on the day he claimed it occurred. These facts provide reasonable explanations for Respondent's denial of Petitioner's claim and show that Respondent's refusal to pay benefits was not frivolous, vexatious or solely for the purpose of delay.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner is not entitled to penalties pursuant to sections 19(k) and 19(l), and attorney fees pursuant to section 16 of the Act.

No bond is required for removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 18 2014
SJM/db
o-02/13/14
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OLIVER, TOMMY
Employee/Petitioner

Case# **11WC028718**

14IWCC0192

RAUSCH CONSTRUCTION CO INC
Employer/Respondent

On 3/9/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0274 HORWITZ HORWITZ & ASSOC
MITCHELL HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

1832 ALHOLM MONAHAN KLAUKE ET AL
BETH YOUNG
221 N LASALLE ST SUITE 450
CHICAGO, IL 60601

14IWCC0192

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tommy Oliver
Employee/Petitioner

v.

Rausch Construction Co., Inc.
Employer/Respondent

Case # 11 WC 28718

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **J. Kinnaman**, Arbitrator of the Commission, in the city of **Chicago, IL**, on **2/21/2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **credit**

FINDINGS

On **7/19/2011**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $**84,801.60**; the average weekly wage was $**1,630.80**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **2** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,087.20/week for 12.429 weeks, commencing 8/1/2011 through 10/25/2011, as provided in Section 8(b) of the Act.
Respondent shall pay reasonable and necessary medical services of $20,510.37, as provided in Sections 8(a) and 8.2 of the Act.
Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 50.6 weeks, because the injuries sustained caused the 20% loss of the right arm, in addition to Petitioner's previous loss of use of 20% of the right arm, as provided in Section 8(e) of the Act. Respondent shall have credit for Petitioner's prior loss of use of the right arm, to the extent of 47 weeks. Petitioner now has a 40% loss of use of the right arm.
Respondent shall pay to Petitioner attorneys' fees of $6,804.64, as provided in Section 16 of the Act; and penalties of $17,011.59, as provided in Section 19(k) of the Act; and $4,230.00, as provided in Section 19(l) of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

March 6, 2012
Date

MAR - 9 2012

This matter was originally tried before Arb. Galicia on Oct. 4, 2011. After the close of proofs, Arb. Galicia's appointment terminated and the case was assigned to the undersigned. On Nov. 10, 2011, Respondent filed a motion for a new hearing, which was allowed. ARBXGroupX4. The claim was tried de novo on Feb. 21, 2012.

Petitioner testified he is a pile driver. A pile driver constructs foundation walls for high rise buildings and to hold back water. He cited the corrugated steel walls used to hold back Lake Michigan around the Shedd aquarium or the walls shown in PX6A around Belmont Harbor as examples. Pile drivers batter a pile into the earth to hold up the sheets and do tie backs to secure the steel walls to the piles. They also do a lot of heavy lifting of things like chain, cable and shackles, lifting up to 150 to 200 lbs. Pile drivers cut and weld the steel sheets, wearing a protective face shield and protective leather so they don't get burned. Petitioner testified he gets bumps and bruises on the job; he doesn't report each one.

Petitioner testified he was working for Respondent on July 19, 2011. They were burning a wall at Belmont Harbor to cut it to grade. This means they were cutting the steel wall so it was level with the ground behind it and the concrete cap could be placed on top. Some of the sheets had chemical in them, which the pile drivers burn off. Petitioner was wearing protective clothing and goggles, not a helmet, because he was just burning, not welding. He was using an acetylene and oxygen torch to cut the steel. He was working with Tita Gosten, a co-worker, to burn off pieces of steel. Petitioner marked PX6A with an X to show where he was positioned. As he was cutting the wall to grade, the fire from the torch on the sheeting and the chemical in the sheeting was extremely hot and caused him to strike the back of his right elbow on the steel. Petitioner testified he said "Damn, it hurts" but figured it wasn't that bad. He kept working and was laid off as of the end of the day. At that time, he noticed there was a little swelling and he had busted the skin a little bit. He did not report the bump to his elbow that day. He testified he is left handed.

Petitioner noticed over the next few days that his arm started swelling. He saw Dr. Waxman on July 25, 2011. The doctor's note shows Petitioner reported he hit his elbow on a metal beam at work a week or so ago. He complained of swelling and some discomfort that night. Dr. Waxman also noted Petitioner had a triceps avulsion which had been repaired 10 or so years earlier. On exam there was swelling over the olecranon bursa of the right elbow with significant weakness of elbow extension. The doctor suspected another triceps avulsion, noting a little bone fragment proximally in the posterior arm. He ordered an MRI. It was done the next day, July 26, 2011 and showed a full-thickness tear of the triceps tendon. PX1.

Petitioner testified he called Respondent on Monday, July 25, 2011 after seeing Dr. Waxman. He spoke to a secretary and asked to get an accident report done. She referred him to Pat, his foreman. He called Pat Kutzer on July 25, 2011and told him he "...wanted to report it because I think I'm hurt." Tr.30. Petitioner testified Pat told him he should

have reported it that day, and would not give him an accident report, even though Petitioner tried to explain he didn't know he was hurt at the time. Petitioner filed this claim on July 28, 2011. ARBX2.

Petitioner underwent surgery on Aug. 1, 2011, a "repair of rerupture, right biceps tendon.". Petitioner's prior surgery and the incident in which he hit his elbow on a steel beam 10 days earlier were both noted in the operative report. It also shows Dr. Waxman identified a defect in the triceps tendon and observed a significant amount of bursal and scar tissue overlying the triceps. The doctor wrote that the appearance of the tissue and all the scar tissue, made it appear Petitioner's ruptured left triceps tendon may not have been just two weeks old, "although the injury and swelling were certainly just at that point, and he had no real significant issues prior to that, so some of the scar tissue certainly could have been from the prior triceps repair." PX2. Petitioner followed up with Dr. Waxman post-surgery and underwent physical therapy beginning Aug. 18, 2011. The therapist recorded Petitioner's report that he was injured when welding and a piece of fire/slag fell on his chest and burned him, causing him to react and hit his elbow on a steel support, rupturing his triceps. Petitioner was discharged from therapy on Oct. 24, 2001. PX3.

Dr. Waxman released Petitioner to return to work with no lifting over 15 lbs. with the right arm and told him to continue his strengthening exercises and not trying to do too much too quickly, particularly at work. On Dec. 14, 2011, Dr. Waxman noted Petitioner was "pretty much doing all of his normal activities" but advised him to slowly get back to heavy lifting writing it could take six to nine months to do so. At that time, Petitioner had full range of motion with some mild triceps weakness, good flexion strength and no tenderness. PX1.

Petitioner testified that when he was released Oct. 25, 2011, he went back to work with the help of others. Most of the time, Petitioner is a foreman. He testified he notices he doesn't have full use of his arm. When he's welding it hurts to keep his right arm elevated. He has pain in the joints of the arm. Lifting hurts especially, lifting something into a truck. He understands this is just something he has to live with. He has not been back to Dr. Waxman. The doctor gave him some pain pills, but he doesn't use them unless it's bad. Petitioner testified he injured his right arm in 1999 when he fell 20 feet while working. He did not remember when he stopped treating for that injury but thought it was about a year later. From 2000 until July19, 2011 he had no treatment for his right arm. Petitioner also testified Respondent has never paid any benefits related to the July 19, 2011 injury, telling him only it was because he didn't report the accident on the day it happened.

On cross-examination, Petitioner testified he had been a pile driver for more than 20 years at the time of his injury. He assumes Tita Gosten saw him bump his elbow. Tita told Petitioner he heard him say he hurt himself and asked Petitioner if he was ok. He hollered out a little bit after he bumped his elbow. But "I didn't holler out because I

thumped by elbow. I hollered out because the fire hit me in the chest. When I hit my elbow, I said oh, shit… and then he asked me, was I okay?" Tr. 47. When he left for the day on July 19, 2011, he knew the job was over. Petitioner testified first that the accident probably occurred in the afternoon, then that it was probably before noon and then that he was assuming it happened sometime in the afternoon. Tr.48-9. In the period from July 20, 2011 to July 25, 2011, he didn't work or do any work around the house or play any sports. On July 19, 2011, he noticed bruising when he got in his truck and pulled off his clothes. He noticed a little blood but didn't pay it any mind and then it started swelling that night and got worse over the next couple of days. He didn't call Respondent or go to a doctor during this period. He only worked for Respondent for three days. They gave him paperwork that included their accident reporting policy that he could have read if he wanted. He fell about 20 ft. on May 4, 1998 and injured his right elbow. He had surgery for that accident. From roughly 2000 to 2011, he never treated for his right elbow. After the rehab, which was painful, his arm was good and he worked full time. He did no gym activities where he was lifting weights in the period from July 19 to July 25, 2011. After he was released to work Oct. 25, 2011, he had a job working for Aretha Construction, but he didn't know the dates when he started and when he was laid off. He last treated for his right elbow injury Dec. 14, 2011.

Patrick Kutzer testified for Respondent. He is a union carpenter working for Respondent as a site superintendent. In July, 2011 he was working for Respondent at Belmont Harbor. Petitioner worked for him as one of a four-man pile driving crew on a Friday, Monday, and Tuesday, which would be July 15, 18, and 19, 2011. During those three days he interacted with Petitioner before work started, at break times and lunch times. On July 19, 2011Kutzer supervised Petitioner's work all day. When he saw Petitioner in the course of the day, he didn't notice Petitioner having any pain or problems. He testified first that he didn't recall speaking to Petitioner that day but then testified he knew they spoke after work because it was Petitioner's last day. Kutzer testified he shook Petitioner's had and thanked him for his help and said he hoped to run into him again on another job. He has not seen Petitioner since July 19, 201. The following Monday Petitioner called to say he wanted Kutzer to fill out an accident report for the last day he was there because he had hurt himself at work. This would have been on July 25, 2011. Kutzer said he "couldn't fill out an accident report a week after the incident occurred." Tr. 67. It was Kutzer's experience as a superintendent or a job foreman that "we have always had to fill it out the day of the incident. I didn't know you could even fill one out after the fact." Tr.68. After July 19, 2011 the job continued at Belmont Harbor but they didn't have work for a four- man crew anymore; other pile drivers were also laid off. Kutzer has burned sheet pile with a torch hundreds of times. You are cutting it with an oxy-acetylene torch. "….sometimes that molten metal or sparks or slag will blow back at you in your direction, not away from you…It happens regularly. Tr.70-1. On cross-examination, Kutzer testified he knows of no factual basis to dispute that Petitioner got injured at work on July 19, 2011, or of any medical basis to dispute the injury. As far as Kutzer knows, the only issue the employer has with this case is that Petitioner reported it six days after the accident.

PX4 consists of Petitioner's medical bills. He is claiming reimbursement pursuant to sec. 8(a) and 8.2 of the Act for unpaid amounts as follows: $13,047.33, Highland Park Hospital; $8,424.72, Illinois Bone & Joint; $1,431.17, Northshore University Health System Anesthesia; $168.78, Northshore University Health System Lab; $429.70, Northshore University Health System Physician Billing; $23,501.70 total. Respondent questioned whether the bills had been fully reduced to the amounts allowed by the medical fee schedule and was given time to do its own analysis of the bills. In its proposed decision, Respondent argued it was not liable for any of the bills. If liability were found, Respondent argued Highland Park Hospital was only entitled to $10,056.00 representing 76% of its charges because the bill did not include CPT codes.

RX2 is a certified copy of the Commission's records in 98WC56083 showing Petitioner's prior settlement for 20% loss of use of his right arm for an accident on May 4, 1998. Petitioner agreed Respondent was entitled to credit for that settlement. Tr.82. In his proposed decision, Petitioner claimed interest on his unpaid medical bills pursuant to sec. 8.2(d)(3) of the Act.

The Arbitrator concludes:

1. Petitioner sustained a compensable accident on July 19, 2011 when he struck his the back of his right elbow on a steel wall. He testified he was cutting the wall using a torch when he was struck by molten metal and, in reaction, hit his elbow. His job superintendent, Pat Kutzer testified sparks or metal or slag regularly blow back on workers. Petitioner described the accident to treating doctor Waxman and his physical therapist. Although Petitioner did not report the accident the same day, his testimony that he did not realize he'd suffered a serious injury was credible. Striking one's elbow is often acutely, but temporarily, painful so a reasonable person might not realize serious there was a serious injury.
2. Petitioner gave timely notice of his accident. Respondent's witness, Pat Kutzer, corroborated Petitioner's testimony that he reported the accident on July 15, 2011, six days after the accident and well within the 45 days allowed by the Act.
3. Petitioner's right triceps rupture was causally connected to his accident of July 19, 2011. Petitioner had a prior right triceps rupture in 1998 which resulted in surgery. There is no evidence he had any complaints, restrictions, lost time or medical treatment to his right triceps in the period between his return to the heavy work of a pile driver in 2000 and July 19, 2011. Dr. Waxman's surgery was to repair the rerupture and he identified the defect, although he was surprised at the amount of scar tissue he found.
4. Petitioner was temporarily totally disabled commencing Aug. 1, 2011 through Oct. 25, 2011, a period of 12-3/7 weeks. This is based on the records of Dr. Waxman showing Petitioner underwent surgery Aug. 1, 2011 and was released with restrictions on Oct. 25, 2011. Although the first off work authorization is dated Aug. 4, 2011, it is apparent Petitioner was physically unable to work beginning the day of his surgery.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ray Williams,

Petitioner,

vs.

No. 11WC009552

14IWCC0193

Rush Medical Center University,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care and temporary disability, and being advised of the facts and law, clarifies the decision of the Arbitrator, as stated below, and otherwise affirms and adopts the decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

The Commission clarifies that the names of the medical practitioners who treated Petitioner at Rush University Medical Center Employee Health, "respondent's facility," are illegible as most of the medical records are handwritten, and it is unclear whether Petitioner treated with a physician named Mamta Malik while at Rush.

14IWCC0193

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed on March 8, 2013, is hereby clarified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner all reasonable and necessary medical expenses for his lumbar spine condition, incurred on or before March 8, 2011, under §8(a) and §8.2 of the Act subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $576.22 per week for 7-2/7 weeks, from January 14, 2011, through March 5, 2011, which is the period of temporary total disability for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

Stephen J. Mathis

DATED: MAR 18 2014
SM/db
o-02/13/14
44

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

WILLIAMS, RAYMOND
Employee/Petitioner

Case# **11WC009552**

RUSH PRESBYTERIAN UNIVERSITY
Employer/Respondent

14IWCC0193

On 3/8/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4188 LAW OFFICES OF KIRK MOYER PC
33 N COUNTY ST
SUITE 602
WAUKEGAN, IL 60085

2965 KEEFE CAMPBELL BIERY & ASSOC
JAMES EGAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

2512 THE ROMAKER LAW FIRM
CHARLES P ROMAKER
134 N LASALLE ST SUITE 840
CHICAGO, IL 60602

☐	Injured Workers' Benefit Fund (§4(d))
☐	Rate Adjustment Fund (§8(g)
☐	Second Injury Fund (§8(e)18)
☒	None of the above

14IWCC0193

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

RAYMOND WILLIAMS
Employee/Petitioner

Case #11 WC 9552

v.

RUSH PRESBYTERIAN UNIVERSITY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on February 14, 2013. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☐ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On January 14, 2011, the respondent was operating under and subject to the provisions of the Act.

- On this date, an employee-employer relationship existed between the petitioner and respondent.

- On this date, the petitioner sustained injuries that arose out of and in the course of employment.

- Timely notice of this accident was given to the respondent.

- In the year preceding the injury, the petitioner earned $44,945.03; the average weekly wage was $864.33.

- At the time of injury, the petitioner was 58 years of age, *married* with no children under 18.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $576.22/week for 7-2/7 weeks, from January 14, 2011, through March 5, 2011, which is the period of temporary total disability for which compensation is payable.

- The medical care rendered the petitioner for his lumbar spine through March 8, 2011, was reasonable and necessary. The respondent shall pay the medical bills in accordance with the Act and the medical fee schedule. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act, and any adjustments, and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, medical benefits, or compensation for a permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert E. Williams

Robert Williams

3/8/13

Date

MAR 8 - 2013

FINDINGS OF FACTS:

On January 14, 2011, the petitioner, an electrician, injured his back while trying to prevent a 12-foot ladder from falling. He received immediate care at respondent's facility for a lumbar strain/lumbago with Dr. Mamta Malik.

A lumbar MRI on January 25th revealed degenerative disc and facet changes at L4-L5 with mild to moderate foraminal stenosis, greater on the right and narrowing of the lateral recesses with mild central stenosis and a small disc protrusion or osteophyte at L5/S1 extending into the left foramen along with degenerative changes involving the left L5/sacral articulation. The petitioner followed up through January 26th, at which time he was released to full-duty work.

On February 5th, the petitioner started chiropractic care with Dr. James Kopsian and was advised not to work. Dr. Aleksandr Goldvekht at Advanced Physical Medicine evaluated the petitioner on February 10th and noted that an MRI showed a L5/S1 disc protrusion with foraminal stenosis. He advised the petitioner not to work. Dr. Goldvekht's diagnosis was lumbar disc syndrome, strain/sprain of the lumbar spine, and radiculitis. He advised the petitioner not to work until March 3rd and prescribed physical therapy, medication and a lumbar orthotic. On March 3rd, Dr. Goldvekht released the petitioner to full-duty work without restrictions beginning March 8, 2011.

On March 7th, the petitioner was evaluated pursuant to Section 12 by Dr. Zelby and reported sharp pains in his low back extending into the lower lumbar region bilaterally since the accident. The doctor opined that except for the petitioner's diabetic peripheral neuropathy and non-anatomic sensory changes, he had a normal neurologic and spine examination and was at MMI.

The petitioner was evaluated by Dr. Harel Deutsch of Rush University on August 26th pursuant to the request of Dr. Rohini Bhat and reported nine months of low back and anterior leg pain that had gradually increased over the past few weeks. Dr. Deutsch noted no low back tenderness to palpation, limited range of motion in all directions, normal paraspinal muscle bulk, no erythema or swelling and a loss of signal at L4/5 and diffuse disc bulging with facet arthropathy on a diagnostic study. On September 13th, the petitioner had an anterior lumbar interbody fusion of L4-5 by Dr. Deutsch at Rush. At a follow-up on October 28th, the petitioner reported some improvement from the surgery and Dr. Deutsch opined that the petitioner should be able to return to work in two months.

On March 28, 2012, Dr. Deutsch opined that the petitioner exacerbated his pre-existing degenerative disc disease condition. X-rays on May 8th revealed a partial sacralization of L5 bilaterally, fusion at L4 and L5 and a narrowing of the L4-5 disc space. On July 3rd, the petitioner saw Dr. Krzysztof Siemionow for an evaluation, who recommended a CT scan and MRI to determine if there was a non-union of the L4-L5 fusion. An MRI on August 2nd revealed the fusion at L4 and L5, an element of congenital mid/lower lumbar spinal canal narrowing and degenerative disc, endplate and joint changes with stenosis worst at L4-5.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for his lumbar spine through March 8, 2011, was reasonable and necessary. The petitioner failed to prove that the medical care rendered after March 8, 2011, was reasonable and necessary, including the lumbar fusion by Dr. Deutsch. The petitioner was released to full-duty work by Dr. Malik on January

26, 2011, and after starting treatment with Dr. Goldvekht on February 10, 2011, he was released to work without restrictions by him on March 3, 2011. He did not complain of back pain or symptoms nor did he seek medical care again until August 28, 2011, at which time he reported that his back pain had gradually increased over the prior few weeks. Also, on March 7, 2011, Dr. Zelby noted that the petitioner's neurological and spine examination was normal and that he was at maximum medical improvement. Further, Dr. Zelby opined at his deposition that the MRI showed that the petitioner's disc space heights were maintained indicating only mild degenerative disc disease, which was not indicative for surgery. Moreover, the petitioner complained that his back pain was worst after surgery. The opinions of Dr. Deutsch and Dr. Siemionow are not consistent with the evidence and are not given any weight.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that his current condition of ill-being with his lumbar spine is causally related to the work injury.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The respondent shall pay the petitioner temporary total disability benefits of $576.22/week for 7-2/7 weeks, from January 14, 2011, through March 5, 2011, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner failed to prove that the care recommended by Dr. Siemionow is reasonable medical care necessary to relieve the effects of the work injury.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

☒ Affirm 07 WC 19768	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with comment	☐ Rate Adjustment Fund (§8(g))
☒ Reverse 07 WC 19686	☐ Second Injury Fund (§8(e)18)
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Timothy Henry,

Petitioner,

vs.

NO: 07 WC 19686
07 WC 19769

Sodexho,

14IWCC0194

Respondent.

DECISION AND OPINION ON REVIEW

Petitioner and Respondent appeal the Decision of Arbitrator Erbacci in a §19(b) proceeding finding that for case 07 WC 19686, Petitioner sustained accidental injuries arising out of and in the course of his employment on June 1, 2006, that timely notice was given to Respondent, that a causal relationship exists between those injuries and his condition of ill-being for his right knee, but that Petitioner failed to prove that a causal relationship exists between those injuries and his condition of ill-being for his left shoulder and left arm, that Petitioner was temporarily totally disabled from November 14, 2007, the date of right knee surgery, through June 11, 2008, the date of a functional capacity evaluation, a period of 30 weeks at $412.00 per week, that Respondent was entitled to credit of $23,739.20 for paid TTD benefits, ordered Respondent to pay all medical expenses for Petitioner's right knee treatment and found Petitioner failed to prove entitlement to vocational rehabilitation and maintenance benefits. The issues on Review are whether Petitioner sustained accidental injuries arising out of and in the course of his employment, whether timely notice was given to Respondent, whether a causal relationship exists between those injuries and Petitioner's current condition of ill-being and if so, the extent of Petitioner's temporary total disability, the amount of reasonable and necessary medical expenses and whether Petitioner is entitled to vocational rehabilitation and maintenance benefits.

The Commission, after reviewing the entire record, reverses the Decision of the Arbitrator for case 07 WC 19686 finding that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on June 1, 2006, failed to prove he gave timely notice to Respondent and failed to prove that a causal relationship exists and denies Petitioner's claim for the reasons set forth below.

Petitioner appeals the Decision of Arbitrator Erbacci in a §19(b) proceeding finding that for case 07 WC 19769, Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on March 27, 2007, failed to prove he gave timely notice to Respondent and failed to prove that a causal relationship exists and denied Petitioner's claim. The issues on Review are whether Petitioner sustained accidental injuries arising out of and in the course of his employment, whether timely notice was given to Respondent, whether a causal relationship exists between those injuries and Petitioner's current condition of ill-being and if so, the extent of Petitioner's temporary total disability, the amount of reasonable and necessary medical expenses and whether Petitioner is entitled to vocational rehabilitation and maintenance benefits. The Commission, after reviewing the entire record, affirms the Decision of the Arbitrator for case 07 WC 19769 for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner filed an Application for Adjustment of Claim on May 2, 2007, which listed a date of accident of June 1, 2006 and alleged injury to the right knee and leg within the course of his employment. This claim was assigned case number 07 WC 19686.

Petitioner also filed an Application for Adjustment of Claim on May 2, 2007, which listed a date of accident of March 27, 2007 and alleged injury to the right knee and leg within the course of his employment. This claim was assigned case number 07 WC 19769.

2. The claims were consolidated for arbitration hearing held on April 25, 2013. Petitioner's attorney voluntarily dismissed case 07 WC 19685, an Application for Adjustment of Claim that was filed claiming a left arm injury on September 1, 2005 (Tr 7). At this hearing Petitioner, a 51 year old school maintenance worker, testified he is not currently employed. He began working for Respondent in 2003 (Tr 9). He worked in the Maintenance Department and would do plumbing, electrical, carpentry and anything else needed at the school (Tr 9). In 2006 the main supervisor was Bruce Davis (Tr 9). Petitioner was assigned to work at Stevenson High School (Tr 10). Petitioner testified that on June 1, 2006, "We got a load of carpeting in and the Maintenance Department was sent out to unload the truck. We had two guys with two different forklifts going. One guy had the skewer that would, like, grab the carpet; and the other guy had a forklift that had a long cable on it, with the bar at the end. My job was to take that, the bar with

the long cable, throw it through the core of the carpeting and it would pull it to the front of the truck. And then I would straighten the bar so he could back up. And then we would go through the whole process again. And then the other person would come and with the other forklift truck with the skewer or whatever and he would take the carpet and take it off of the truck, once it was at the back of the trailer. So I had – Well, I was working with Jim Managо with the cable and the bar, going through, and then Jose Rivera was the guy on the forklift truck. And we were going along for a while. And then Bruce Davis all of sudden was on the forklift truck and he came in. I had three carpets there because – well, I had three carpets lined up in the back of the truck, and he came in really fast because he hadn't been there because Jose was driving the truck, and then he skewered the one load of carpet and I was still trying to get the – or I had just gotten the cable out of the roll, and when he started he skewered the roll and I didn't have a chance to back up because there were, like, eight or ten-foot rolls of carpeting, you know, like this big (indicating), like – I don't know how to say that, you know, for Henry, but you couldn't put your arms; they were real big. The diameter of the carpeting, yeah, right. So when he skewered it and he started to back up, he didn't go straight. He went at an angle. And what it did, I was trying to back up away from the carpeting to get out of the way and he pinned my leg between two rolls of this carpeting" (Tr 10-11). "My right leg. And as he was backing up and he was kind of like lifting at the same time, well, first my leg got crushed in. And I said, "Well," to myself, "this isn't too bad because it's just, you know, pressure." But as he was lifting up and going out at an angle and he was pushing the carpeting in, it cleared the top roll of that piece of carpeting and he steamrolled me and it twisted the top part of my body in a circle, while the bottom – well, well, below my knee was trapped between the two big rolls of carpeting." (Tr 12-13). Mr. Davis lifted the roll and left with it. Petitioner was in a lot of pain. He was able to push the roll of carpet with his other leg and free himself (Tr 13). His right leg was really hurting (Tr 13).

Petitioner testified that Jim Managо came up with the other forklift and asked him what was going on because he was acting a little different (Tr 14). Jim Managо was kind of the go-to guy and, "He is not really an official supervisor, but he is put in charge when there is no other supervisors around." (Tr 14). Jim Managо had been at the school since it opened. Jim Managо can tell Petitioner where to go and what to do and to stop doing some sort of activity and do something else (Tr 14-15). Petitioner observed Jim Managо exercising supervising other employees (Tr 16). When Jim Managо came into the trailer, Petitioner told him, "I told him that Bruce just hit me or he just twisted me up with the forklift truck." (Tr 16). Petitioner testified he got himself out of the truck and started going into the building. He heard Bruce Davis zipping around in the forklift and Petitioner looked at him and stayed out of his way and found himself a quiet corner (Tr 17). He rested and did not do anything after that (Tr 17). At that time, Petitioner did not think he could do anything and was hobbling and limping (Tr 17).

Towards the evening, Petitioner spoke with night supervisor Calvin Carter in the Maintenance Department by his toolshed (Tr 18). No one else was present. Petitioner testified he told Calvin Carter, "Bruce hit me with the forklift truck." (Tr 18). Petitioner then went home (Tr 18). The next day, Friday, June 2, 2006, Petitioner took it real slow as he was hurting and

did not do much (Tr 18-19). He relaxed over the weekend and he did not take pain medications (Tr 19). Petitioner took a vacation at the end of July 2006 (Tr 19). Over his vacation, his right knee got better (Tr 20). Petitioner thought it was something that would just pass (Tr 20). He returned to work after his vacation and continued to work through March 26, 2007. During that time, Petitioner continued to work pretty much on his own and did what he wanted. He vacuumed the dryers in the bathrooms and also worked on the drinking fountains (Tr 21). He would feel better and then do something heavier and his right leg and left arm would hurt and he would stop (Tr 21).

On March 26, 2007, Petitioner was working in the new building and they were taking up carpeting. They were pulling the carpeting off the floor (Tr 22). He began work at 8:00 a.m. and worked through the day (Tr 22). Removing the carpeting entailed using a shovel and spade with a flat edge. Petitioner testified, "I would put the shovel in my left hand, the handle. And then the right hand I grabbed, you know, towards the base. And I would take it and I would jam it between the cement floor and the carpeting where the grove was. And you just keep on slamming it, trying to break the bond between the carpeting and the cement floor." (Tr 23-24). He had to use his upper body to push (Tr 24). His motion was like a baseball pitcher, bending his legs, throwing back his left leg, bending his right leg, twisting his body, bending his torso and slamming into it (Tr 24). He is tall and had to bend his right knee to get lower into the carpeting (Tr 24). He was using his left hand and his whole left arm for slamming and his right arm for lifting (Tr 25). Petitioner worked with the carpeting all day. The carpeting was cut into rolls and he was supposed to carry the rolls to a truck outside. By the end of the day, Petitioner could not get the carpet rolls on his left shoulder anymore as he did not have the strength and the pain was starting to overtake him and he just could not do it anymore (Tr 26). His left shoulder and right leg were in pain (Tr 26). Every slam would jar his body (Tr 26).

Petitioner testified he came to work on March 27, 2007 and tried to do carpet removal (Tr 27). He put in about 3 slams and could not take the pain anymore. Petitioner testified, "My leg, my arm, my entire body, I was so racked with pain I didn't know where it was coming from at that point in time." (Tr 27). He told the guys, "I'm just not a mule. I can't take it anymore. This is it, guys." Petitioner stated that the guys said they would cover for him and he said he could not (Tr 27). Petitioner went to Bruce Davis and said, "I can't take it anymore. I've got to go, you know, I've got to see a doctor. I just can't take it anymore." (Tr 27-28). Petitioner testified that Bruce Davis said, "Well, go." (Tr 28).

Petitioner testified that he had his own tools at work and carried those tools on his left shoulder and experienced pain (Tr 28). Later, he acquired a cart to carry his tools. His toolbag weighed only about 10 pounds or so (Tr 29). He carried his toolbag at Respondent's facility on his left shoulder for 4½ years (Tr 29). He started using the cart after he started having pain in his left shoulder (Tr 29). Petitioner's conversation with Bruce Davis occurred on like April 3, 2007 or something like that. He had called Bruce up and he was on vacation, so Petitioner had to wait until he came back from his spring break vacation (Tr 29). When he talked to Bruce Davis on

March 27, 2007, Petitioner told him about both his left shoulder and right knee and that he was so racked with pain that everything hurt (Tr 30). Petitioner was not exactly sure if he came to work between March 28, 2007 and April 4, 2007, but he remembered they said they were still doing carpeting and not to come in (Tr 30).

Petitioner testified he saw Dr. Young on either April 3, 2007 or April 4, 2007 (Tr 31). Respondent's attorney stipulated to the deposition testimony of Dr. Young with respect to Petitioner's medical treatment (Tr 31). Petitioner believed Dr. Young gave him restrictions (Tr 32). Prior to Dr. Young giving him restrictions, Petitioner did not have restrictions for his left shoulder or right knee (Tr 32). Petitioner gave those restrictions to Arland at Respondent's facility (Tr 32). Petitioner thought Bruce Davis was on a fishing trip at that time (Tr 32). When he gave him the restrictions, Arland walked back into Ted Yarborough's office; Petitioner was not in Ted Yarborough's office and did not overhear what they were saying; Arland was an appointed supervisor (Tr 33-34). Petitioner thought Arland came out and told him that Ted Yarborough wanted to talk to him (Tr 34). Petitioner thought he went into Ted Yarborough's office and talked to him (Tr 34). Petitioner stated that Ted Yarborough told him, "Don't come back until your restrictions are lifted." (Tr 34).

Petitioner testified he underwent a right knee MRI on April 18, 2007 (Tr 34). Dr. Young recommended right knee surgery on June 11, 2007 and continued his restrictions (Tr 35). Petitioner underwent right knee surgery on November 14, 2007 (Tr 35). Petitioner identified Px15 as a true and accurate copy of the FMLA papers he received from Bruce Davis (Tr 35). He did not fill out any of those documents himself and there was handwriting on the papers already (Tr 35). Petitioner saw that Bruce Davis had signed and dated the first page of Px15 June 19, 2007 (Tr 36). On the second page of Px15, Bruce Davis gave him until July 2, 2007 to return the documents (Tr 36). Petitioner did not checkmark Section 1 of the Leave of Absence Form, which states, "Unable to perform job due to serious medical condition" and "This condition is as a result of working at Sodexho"; both are checkmarked with an "X" (Tr 36). Those checkmarks were there when Petitioner received the document (Tr 36). On July 11, 2007, Petitioner received a letter from Respondent terminating his employment (Tr 36). Petitioner identified Px10 as a true and accurate copy of this letter (Tr 37). The letter is from Ted Yarborough. Mr. Yarborough never offered him a job within his restrictions (Tr 37-38). Petitioner continued to have restrictions. Petitioner stated that workers' compensation approved the right knee surgery on October 13, 2007 and he had the surgery on November 14, 2007. On December 4, 2007, Petitioner underwent a left shoulder MRI. He underwent some physical therapy for his left shoulder until the beginning of 2008 (Tr 38). Petitioner paid for physical therapy through COBRA insurance (Tr 39). Workers' compensation did not approve the physical therapy (Tr 39). Through February 22, 2008, no doctor had released him to return to work (Tr 39). Dr. Young recommended a functional capacity evaluation on February 22, 2008.

Petitioner testified he underwent a functional capacity evaluation on June 18, 2008 (Tr 39). No doctor had released his restrictions between February 22, 2008 and June 18, 2008

(Tr 39). After the functional capacity evaluation was completed, no one from Respondent offered him his job back within the parameters of the functional capacity evaluation (Tr 40). Workers' compensation did not provide any vocational training after the functional capacity evaluation (Tr 40). Petitioner was initially represented by Newland, Newland & Newland (Tr 40). Mr. Newland had attempted to obtain vocational retraining for him, but workers' compensation did not approve vocational retraining after his attorneys made a demand for same (Tr 40). At Respondent's request, Petitioner underwent a §12 evaluation by Dr. Papierski on February 5, 2009 (Tr 42). Petitioner stated he had to wait a year before he received TTD benefits through June 11, 2008 (Tr 42). He saw Dr. Young again on May 8, 2009 and on June 9, 2009, but did not recall if he recommended anything in terms of trying to find employment (Tr 44).

Petitioner testified that on September 22, 2009, he looked for work everywhere in Lake Zurick he could think of (Tr 44). He went to the College of Lake County and met with a counselor named Candy McMahon for an analysis (Tr 44). Ms. McMahon gave him a test to see what he would be good at doing (Tr 45). Prior to going to the College of Lake County, Petitioner looked for work on his own, but was not able to find anything (Tr 45). On November 16, 2009, Petitioner met with Ed Pagelia for a vocational assessment that was requested by Newland, Newland & Newland (Tr 46). Petitioner remembered he went back to the College of Grayslake after he saw Mr. Pagelia to learn how to do a job search (Tr 46). He continued to look for work. Beginning on February 11, 2009, Petitioner started keeping a log of his job search (Tr 46). He did not recall how long he kept a log for (Tr 46). Petitioner identified Px13 as a true and accurate copy of the job log he did (Tr 47). He would not have any reason to dispute that the job log shows he continued it through June 1, 2010 (Tr 47). Petitioner guessed he applied for or listed 250 jobs (Tr 47). He also looked for approximately 50 jobs that are not listed in his logs (Tr 48). Petitioner did not continue to look for work after his log ended on June 1, 2010 as he was driving his car into the ground and it cost money and he did not have money coming in (Tr 48). Since June 2010, Petitioner has stayed home a lot, he went grocery shopping and he got Social Security Disability, which saved his life (Tr 48).

Petitioner testified he returned to Dr. Young on November 14, 2011 and he continued his restrictions (Tr 49). Through the years his left shoulder has been getting worse. When he tries to hang his laundry, he cannot even hold a clothespin and his left shoulder and left arm cave (Tr 49). He has left shoulder pain into his left arm (Tr 49). Petitioner has difficulty sleeping with his left arm and he does not know what to do with it as it is hurting (Tr 50). His right knee is not too bad. Petitioner can feel great, but if he stands up and does the dishes and if he leans forward too far and hits the spot where cartilage was taken out, he can be down for 2 days (Tr 50). For his right knee, Petitioner does not even want to get out of bed as his right knee hurts. Sometimes he is in right knee pain so badly he regrets having to go to the bathroom (Tr 50). The pain overtakes the pleasure during sex, so that is over with (Tr 51). Petitioner can stand up and go down and he sits and stands as far as he has to. He drove his car for an hour and had to take a break because the pain was so bad from being crunched up. He has to be able to stretch his right knee (Tr 51).

3. On cross-examination, Petitioner testified that one of his resumes is on top of his job search documents (Tr 51). He typed the resume and can use a computer (Tr 52). He cannot type and he pecks. He was a technician (Tr 52). The resume was done after July 2007. He first sent out his resume sometime in 2008 (Tr 52). The pictures in his job search logs were from businesscards he got from the places he went to looking for work (Tr 53). Petitioner would go into a business and ask for a job. On Page 1 is listed Affiliated Enterprises, which did not have a businesscard; Petitioner went to human resources there and was open to do anything they wanted; they did not advertise a job opening. Only the ones listed with a newspaper ad were looking for employees (Tr 54-55). The first 19 pages of his logs, Petitioner just walked in and asked, "Can I work for you?"; they were not advertising to hire people (Tr 55). Thirty pages of Px13 were cold calls (Tr 55). Petitioner testified he applied for every single job listed in Px13 (Tr 56). There was an ad for a fire service technician for which Petitioner sent a resume to; there was no phone number or address to follow-up; this was on the internet and Petitioner did not receive anything from anybody (Tr 56-57). In Wauconda there was an internet ad for a computer technician for which Petitioner sent a resume to, but he got no response (Tr 57). ITW was looking for a mold maintenance technician with a minimum 5 years of experience in plastic injection molding. Petitioner acknowledged that he did not have 5 years of injection molding experience (Tr 59-60). If there was something on the internet, Petitioner would send something on the internet (Tr 61). He did not know how to follow-up on the internet and that is what he needed help with (Tr 61). He did not follow-up on any of the resumes he sent on the internet (Tr 61-62). Petitioner did not go back to Respondent and ask for work, even after the functional capacity evaluation (Tr 62).

Before he worked at Respondent, Petitioner worked at Distinctive Business Products in Rolling Meadows as a field service technician for 2 years (Tr 63). He would go out and fix copiers. Before that, he was a service technician at Monotype Systems and he would repair typesetting machines and get new equipment ready to be sold (Tr 64). Before that, Petitioner worked for Plum Resources in Schaumburg from 1992 to 1993, where he made toner cartridges and recycled them, purchased supplies and trained personnel as a supervisor (Tr 67). Before that, he worked as a field service technician at Auto Logic in Des Plaines and did the same kind of thing working on copiers, laser printers and repairing them. Before that, Petitioner was a journeyman typesetter with Local 16 and worked at Writer-Types, a typesetting company (Tr 68). In his job search, Petitioner did not apply for a typesetter job because they no longer exist (Tr 68). Petitioner would tell a prospective employer that he cannot kneel, squat or crawl (Tr 72). He was looking for anything he could get (Tr 72).

The first time Petitioner saw his doctor was in April 2007 (Tr 73). He told Dr. Young the truth (Tr 73). Petitioner identified Rx1 as an Application for Adjustment of Claim that was filed claiming a left arm injury on September 1, 2005 and was filed in 2007 (Tr 73-75). Petitioner identified Rx2 as an Application for Adjustment of Claim with a date of accident of June 1, 2006 for a right leg injury. This is the accident he described with the rolls of carpeting (Tr 75). Petitioner identified Rx3 as an Application for Adjustment of Claim with a date of accident of

March 27, 2007 also for a right leg injury (Tr 76). Dr. Young's records would be false if they do not show any complaints of the left shoulder when he first saw him (Tr 76-77). Petitioner worked full duty for Respondent between September 1, 2005 and June 1, 2006 (Tr 77). During that period, Petitioner did some carpeting, ran some electrical lines, did some plumbing work, installed sinks, repaired hand dryers, repaired water fountains, repaired hand railings on the stairs and did some painting (Tr 77-78). From June 1, 2006 to March 27, 2007, Petitioner was doing his full job duties and all the things he just testified to (Tr 78-79). Other than breaks, he would be walking around and standing or kneeling or doing whatever (Tr 79). Petitioner stated that from March 27, 2007 until he sought treatment on April 4, 2007, he was told not to come back to work because they were doing carpeting and not to come back until they were not doing carpeting (Tr 80). Petitioner did not ask Bruce Davis, Calvin Carter, Jim Manago or Theodore Yarborough to come testify for him (Tr 80). Petitioner was provided a copy of the functional capacity evaluation, but did not remember when (Tr 81). Petitioner guessed he last saw Dr. Young in 2008 for his right knee (Tr 81-82). He has not seen another doctor since he last saw Dr. Young (Tr 83). Petitioner applied for Social Security Disability on October 18, 2011 and was awarded same (Tr 83). Social Security Disability benefits were backdated a year from the time he was granted them (Tr 85-86). He has never applied for unemployment benefits because he could not work (Tr 86).

Petitioner was shown Px15, the leave of absence request packet (Tr 86). Bruce Davis signed Page 2 and Page 3 of Px15 (Tr 86). The packet informed him about his eligibility for leave of absence and FMLA (Tr 87). Part of the packet is a medical certification form that his doctor is supposed to fill out. Petitioner did not ask his doctor to fill out this form (Tr 88). Petitioner also did not ask his supervisor to complete his part of the form (Tr 88). Petitioner acknowledged he got a letter from Respondent telling him he had failed to fill out the form and that was the reason he was terminated (Tr 88). Petitioner lives in a house which has stairs. He does his own repairs around the house. He does as much as he can regarding laundry, grocery shopping and yard work (Tr 89). During the carpeting event of June 1, 2006, Petitioner was the only one inside the truck (Tr 89). The first person that saw him there was Jim Manago (Tr 89). By the time Jim Manago saw him, Petitioner was in the process of standing up (Tr 89). Petitioner guessed Respondent gives employees two weeks of vacation time (Tr 90). Petitioner could not remember when he took his vacation in 2006 (Tr 90). Arland Aldridge worked for Respondent and left his employment about the same time when Petitioner was terminated (Tr 91). Dr. Young gave Petitioner restrictions on April 4, 2007 (Tr 91). Petitioner took those restrictions to Respondent, but did not remember who he gave them to (Tr 92). His doctor had ordered the functional capacity evaluation (Tr 92). Petitioner was not sure if he gave the functional capacity evaluation report to Respondent, but he thought the lawyers had it (Tr 93).

4. On re-direct examination, Petitioner testified that in Px15 job search documents, there is some reference to Monster.com and he filled out their online application. Petitioner identified Px17 as copies of his vacation time slips (Tr 94). Px17 shows Petitioner took a vacation in

July 2006. His heat exhaustion problem was in 2005. Px17 shows Petitioner was on vacation from week ending July 28, 2006 through the week ending August 11, 2006 (Tr 95). Petitioner received several restrictions from Dr. Young before he was terminated from Respondent (Tr 95). For each of those restrictions, Petitioner would go in to Ted Yarborough and give him the restrictions (Tr 96). Petitioner was not sure who he gave the April 4, 2007 restrictions to at Respondent (Tr 96). On re-cross examination, Petitioner testified that between June 1, 2006 when he hurt his right knee until when he began vacation on July 21, 2006, he worked at Respondent with his right knee hurting (Tr 98).

5. Petitioner's attorney made a motion to amend the Application for Adjustment of Claim for 07 WC 19769 (date of accident March 27, 2007) to add injury to Petitioner's left shoulder (Tr 99-100). Over objection, the Arbitrator allowed the Application for Adjustment of Claim to be amended to include injury to the left shoulder (Tr 101).

6. David Patsavas testified that he is a certified vocational rehabilitation consultant and has been since 1982 (Tr 103). His qualifications and experiences are listed in Rx4, his CV (Tr 103). He has been working in the field with work-related injuries in Illinois since 1986 (Tr 104). His assignments are 2/3^{rds} from employers and 1/3rd from injured workers (Tr 104). Petitioner's attorney objected, indicating he had not received any report from this witness as to what his opinions were going to be. Petitioner's attorney also observed Respondent's attorney provide Mr. Patsavas the job search documents during trial, which he believed was improper (Tr 104-105). Petitioner's attorney argued that under *Ghere* and the Rules, the Witness should not be permitted to provide opinions in this matter (Tr 105). Respondent's attorney stated that he had asked Petitioner's attorney for the job search records years ago and they were not provided (Tr 105). Respondent's attorney reminded the Arbitrator that there had been a hearing in front of him and at that time, Respondent's attorney requested the vocational counselors come in and testify live. At that time, the Arbitrator suggested the parties depose the vocational counselors. Respondent's attorney indicated that Petitioner's attorney never submitted his vocational counselor for deposition and that Respondent's attorney was bringing his vocational counselor to testify live because the depositions were not taken (Tr 105). Respondent's attorney argued that Petitioner's attorney knew that there were vocational rehabilitation witnesses on both sides (Tr 105). Petitioner's attorney indicated that he and Respondent's attorney had talked on a few occasions of why Petitioner's attorney was not taking the deposition of his expert. Petitioner's attorney did not want to take the deposition of his expert prior to receiving a report from Respondent. Petitioner's attorney indicated that Respondent's attorney was refusing to provide any report from Mr. Patsavas prior to taking his expert's deposition (Tr 106). The Arbitrator noted Petitioner's attorney's objection and reserved ruling on his objection and told him to raise it again in his Proposed Decision (Tr 107). The Arbitrator allowed Mr. Patsavas to testify (Tr 107).

Mr. Patsavas reviewed a copy of Px15 job search documents 2008 through 2010 a few minutes prior to this hearing (Tr 108). Mr. Patsavas opined that Petitioner did not conduct an adequate job search (Tr 109). There were too many gaps in the dates listed. He noted there is a reference to utilizing the College of Lake County job placement in September 2009 and there is a follow-up two months later and nothing else after that date. Mr. Patsavas was fully aware of the Lake County Job Placement Office, which offers job fairs at the college twice a year, and he did not see any listing for those. Mr. Patsavas did not see any confirmation of job applications submitted, except one or two. There was one rejection letter. He stated that if there is a resume attached there is a confirmation letter or e-mail that comes back to the individual that documents that they actually applied for the position (Tr 110). Mr. Patsavas opined that a good job search, a rehabilitation plan submitted to the IWCC, has usually a minimum of 20 employer contacts per week, an average of 3 to 4 per day. There could be job fairs, there could be direct contact with employers, there could be more internet applications and to just attach the resume to whatever job they are applying for (Tr 110). Mr. Patsavas thought Lake County had a number of manufacturing-type positions, assembly, CNC operators, security, just like most other counties around Chicago (Tr 110-111).

Mr. Patsavas reviewed Petitioner's resume. He opined that Petitioner had a solid work history from 1974 through July 2007 and opined he had transferrable skills (Tr 111). At Respondent's request, Mr. Patsavas had reviewed Petitioner's June 2008 functional capacity evaluation report. Mr. Patsavas opined that based upon Petitioner's resume and the his functional capacity evaluation report, Petitioner should be able to go back to a similar type of position that he was performing before, as far as maintenance technician, but there may be some accommodation needed (Tr 112-113). The functional capacity evaluation report indicated that Petitioner was functioning at least at the heavy to very heavy category of physical demand (Tr 113). Mr. Patsavas conducted a labor market survey based on the Illinois Department of Employment Security wage analysis for the second quarter of 2010. The labor market survey covered the period from March 1, 2012 through March 25, 2012. Mr. Patsavas concluded that the entry level average for Lake County is $10 per hour, $18 to medium level and up to $35 with experience (Tr 115). Some assembly-line positions could be anywhere from $13 to $18 per hour and up (Tr 115). Mr. Patsavas opined that Petitioner was not an entry-level applicant, unless he went to a job that was totally outside of his work experience (Tr 115). Within his work experience, the range of salary were between $13 and $18 per hour (Tr 115).

7. On cross-examination, Mr. Patsavas testified that he was first contacted by Respondent's attorney in February 2012 by phone and was hired to review Petitioner's file and offer review of records, along with performing a labor market survey. Mr. Patsavas reviewed the functional capacity evaluation report, Operative Report for the right knee surgery, a report from Mr. Pagelia and two reports from §12 Dr. Papierski (Tr 116). Mr. Patsavas drafted his report on April 4, 2012 (Tr 116). Mr. Patsavas provided that report to Respondent's attorney and he probably would have received it within a week of April 4, 2012 (Tr 117). He had no other correspondence with Respondent's attorney (Tr 117). Mr. Patsavas gave the report to Petitioner's attorney for

his review (Tr 117). He has worked with Respondent's attorney a half dozen times directly and with his office a dozen times (Tr 118). He gets paid $125 an hour and thus far he guessed his services were $1,000. Mr. Patsavas had reviewed Px13 job search documents a few minutes before testifying (Tr 118). He was aware the functional capacity evaluation report listed that Petitioner had difficulty holding up his arm and working overhead (Tr 120). He did not contact any of the employers he listed in his report to see if they had jobs available (Tr 120). Mr. Patsavas was shown Px18, an employability study done by Edward Pagelia, and stated he had reviewed this (Tr 121). He knows Mr. Pagelia on a professional basis (Tr 121). He understood Mr. Pagelia to be a competent vocational counselor and acknowledged that opinions can differ (Tr 121). Mr. Patsavas was not asked to provide Petitioner with placement services (Tr 122). Mr. Patsavas opined that based on the functional capacity evaluation results and Dr. Papierski's release, Petitioner would not require vocational assistance (Tr 123).

8. According to the medical records from Lake Cook Orthopedic Associates, Px6, Petitioner saw Dr. Young on April 3, 2007. The following history was noted, "This is a 51-year old patient who has had pain in his left shoulder and elbow for one year and has had pain in his right knee since June of 2006. He has difficulty with heavier workloads, particularly moving heavy objects. His problem with his knee began last summer when they were removing carpets at Stevenson High School where he is an independent maintenance contractor. He sustained an injury to the knee. His immediate boss was driving the forklift and his knee was pinned between two rolls of carpet. He was bumped and his body twisted while his leg was pinned. His knee became quite painful. He was hobbling and was noted to be dragging his leg for a period of time. This seemed to partially resolve after a vacation. When he returned to work, he had recurrent symptoms. He is having difficulty with stairs and ladders. He feels that the knee "separates" at times. The symptoms are on the inside of the knee with sharp pain; the patient points to the medial aspect of the knee. He has had symptoms in the left shoulder and elbow for about one year. He was performing heavy work, using a shovel or scraper to elevate carpet which had adhered to the floor. He was unable to continue this activity due to discomfort in the shoulder and elbow. He was told to go home. He had difficulty lifting a piece of plywood with the left arm. He believes his arm symptoms were increased by carrying a heavy tool bag over the left shoulder, as required by his employers, but he subsequently began to carry his tools on a cart because his shoulder pain was too intense."

On examination of the right knee, Dr. Young found tenderness along the medial joint line with a positive McMurray sign and there was no effusion or ligamentous laxity. On left upper extremity examination, Dr. Young found tenderness along the medial aspect of the left elbow, no instability, shoulder function was full and there was excellent strength, there was tenderness along the left AC joint and subacromial space and a positive arc sign. Right knee x-rays were taken and Dr. Young found them to be normal. X-rays of left shoulder were taken and revealed an os acromiale, but no other substantial bony anomalies. Medications were prescribed and a right knee MRI was ordered. Dr. Young noted that if meniscal damage was demonstrated, surgery may be considered. If there was no damage, then a rehabilitation exercise program for

his right knee and left shoulder would be recommended. He would consider a left shoulder MRI if symptoms continued. Dr. Young explained to Petitioner that the os acromiale is not a condition which was caused by his work and that it is something he probably has had since childhood. Dr. Young noted, "He apparently did not report the previous knee injury to his employers for fear of retribution since his boss was driving the forklift when he was injured but he feels something needs to be done as it has become apparent that his symptoms are not improving with time as he had hoped." Dr. Young noted that he was faxing his notes to Dr. Segal and that a workers' compensation claim to Gallagher-Bassett was pending.

On April 24, 2007, Petitioner reported ongoing problems, specifically with his right knee. It had continued to bother him particularly along the medial side, but not as greatly as in the past. He had difficulty sleeping at night and was symptomatic daily, but not as bad as his initial injury in June 2006. There was no change of the examination findings. Dr. Young reviewed the right knee MRI and it revealed some increased signal intensity in the medial meniscus and there did appear to be a tear in the medial meniscus, but not in the lateral meniscus and the ligamentous and tendinous structures appeared to be intact. Dr. Young's assessment was Petitioner was symptomatic with a right knee meniscal tear. Dr. Young recommended right knee arthroscopy and partial medial meniscectomy, to be scheduled in the near future. Petitioner reported he was having great difficulties with the workers' compensation adjuster.

Dr. Young noted on June 22, 2007 that Petitioner was last seen almost 2 months ago. Petitioner reported his right knee symptoms continued daily with his knee feeling swollen and stiff. He felt a sensation of shifting and had increased pain with full extension. Petitioner ambulated with an obvious limp. On right knee examination, Dr. Young found tenderness along the medial joint, slight effusion, lacking full extension and the last few degrees of extension were limited and there was no ligamentous laxity. Dr. Young's assessment was a meniscal tear. He noted that apparently there was considerable reluctance from workers' compensation to proceed with surgery. He noted Petitioner was not working. He noted Petitioner was previously doing some very heavy labor, removing and installing carpeting and heavy custodial work. Dr. Young opined that Petitioner was not able to function in his normal job at that point. Dr. Young released Petitioner to return to work with restrictions of no lifting, no squatting, no crawling, no kneeling, no pushing, no pulling, no climbing, no ladder or scaffold use and no carpet removal. He would await approval for the right knee surgery.

9. In a letter to Petitioner dated July 11, 2007, Px10, Theodore Yarbrough informed him that his employment with Respondent was terminated effective July 13, 2007. Mr. Yarbrough informed Petitioner, "You are not able to perform the essential functions of your job and you have failed to request a leave of absence with the forms you received on June 19, 2007."

10. According to the medical records of Lake Zurich Family Treatment Center, Px5, Petitioner saw Dr. Segal on November 9, 2007 for a pre-operative physical examination. Dr. Segal noted the following history, "In June pt got twisted all body between rolls of carpet and forklift truck, since than c/o severe pain right knee." Petitioner was cleared for surgery.

11. Advocate Good Sheperd Hospital records, Px3, indicate Petitioner underwent surgery on November 14, 2007. In his Operative Report of that date, Dr. Young noted a pre-operative diagnosis of medial meniscal tear right knee. Dr. Young performed an arthroscopy with multi-compartmental synovectomy. Dr. Young's post-operative diagnosis was chondromalacia patella lateral tibial plateau, medial tibial plateau, medial femoral condyle and multi-compartmental synovitis.

12. Dr. Young saw Petitioner on November 30, 2007 and noted Petitioner had undergone a right knee arthroscopy with multi-compartmental synovectomy and partial medial meniscectomy. Petitioner reported that his right knee was feeling dramatically better than prior to surgery. Petitioner reported he continued with left shoulder problems. Petitioner was to continue strengthening and massage for his right knee. Dr. Young noted that Petitioner's left shoulder continued to be painful since the time of his first visit. Dr. Young noted that the right knee seemed to take precedence as it was giving him a great deal of discomfort at that time. Petitioner reported that his job had been terminated since his previous visit. Petitioner complained of pain which radiated from his trapezius into his triceps and elbow and into his fingers. He had symptoms when working overhead and felt very tired. He could only use his left arm overhead for short periods. Petitioner reported that at the time of his injury, he was unable to flex his arm, but it seemed to gradually improve. However, he was continuing to have difficulties with his left shoulder on a daily basis. It felt like there was a weight on his left shoulder, which radiated to his elbow and forearm and he had a right sensation in his elbow. On examination of the left shoulder, Dr. Young found some tenderness along the trapezius and neck motion may be slightly correlated to his symptoms, finger, wrist and elbow function were totally normal, strength was normal, there was tenderness in the subacromial space and sensation was equivocally abnormal in the median nerve distribution of his left hand. Dr. Young's assment was that Petitioner may have sustained a traction injury to his left neck with continued symptomatology into his left hand. Dr. Young prescribed medications and ordered a left shoulder MRI and an upper extremity EMG.

On December 10, 2007, Dr. Young reviewed the left shoulder MRI, which revealed some mild degenerative changes in the AC joint as well as an os acromiale. There was no obvious rotator cuff tendon tear and no evidence of bicipital or labral abnormalities. Dr. Young noted, "I have discussed with him an os acromiale is a developmental problem. It is not acquired. It can be asymptomatic for years and then develop symptoms with this. Acromioclavicular arthritis similarly can be present for a prolonged period of time and then become increasingly symptomatic. I think the best course is probably not surgical in this patient as many of these will

resolve with more conservative measures including rehabilitative courses and anti-inflammatories, et cetera." Dr. Young prescribed medications and ordered physical therapy for his left shoulder. Dr. Young noted that right knee function was improving. (Px6).

13. According to the medical records of Barrington Rehabilitation and Sports Medicine, Px2, Petitioner was seen on December 11, 2007. In a Shoulder/Elbow Pain and Disability Index form that date, Petitioner noted the following history, "I have carried a tool bag "10 LBS" on my left shoulder for 3 years and now I have a constant dull ache throughout the shoulder. When holding my left arm up for a length of time such as holding electrician wiring I have to stop due to pain. Also lifting 75-100 LBS my left arm has lost its strength." In the Physical Therapy Shoulder Evaluation Report that date, the therapist noted that Dr. Young had referred Petitioner and diagnosed os acromiale and degenerative joint disease of the AC joint. The therapist noted Petitioner reported a history of repetitive use. The therapist noted, "Pt reports he was taking out carpet & his shoulder was hurting. Pt reports he has been holding a tool bag on his left shoulder. Pt has difficulty doing heavier work. Pt reports weakness & numbness & tingling into his LUE. Pt has difficulty doing any overhead task which he is required to do for work." On December 26, 2007, the therapist noted that Petitioner had attended 6 physical therapy sessions and reported his left shoulder was feeling better and felt stronger. Petitioner was to continue physical therapy for his left shoulder.

14. Dr. Young noted on January 8, 2008 that Petitioner was seen for his left shoulder, right knee and right great toe, which was from a high school injury and unrelated. Petitioner reported his right knee was very functional and he was quite pleased with the post-operative results. Petitioner reported his left shoulder was improving and physical therapy seemed to be helping with less pain and improved functioning. On right knee examination, Dr. Young found Petitioner ambulating without a limp, no crepitus, no instability, no effusion or erythema. On left shoulder examination, Dr. Young found nearly full range of motion, but it continued to be somewhat weak. He suspected gout of the great toe and prescribed medication. (Px6).

On February 20, 2008, the therapist at Barrington Rehabilitation and Sports Medicine noted that Petitioner had not returned for physical therapy since December 31, 2007. Petitioner was discharged from physical therapy. (Px2).

15. On February 22, 2008, Dr. Young saw Petitioner for his left shoulder and right knee. Petitioner reported he was generally better than prior to surgery, but still had cracking sensation in right knee. He had symptoms with using stairs, squatting or crawling. He had left shoulder difficulties, but was generally better. Petitioner reported that workers' compensation sent him 5 checks, then cut him off again. Petitioner reported that physical therapy had been curtailed as workers' compensation was not paying for that. Dr. Young noted that Petitioner had been doing better with physical therapy, but now the problem was starting to recur. Dr. Young found the same on right knee examination. On left shoulder examination, Dr. Young found range of motion somewhat limited at the extremes and somewhat uncomfortable with resistance.

Dr. Young recommended Petitioner undergo a functional capacity evaluation. On March 28, 2008, Dr. Young noted that Petitioner was the same and that workers' compensation was denying coverage for the functional capacity evaluation. He would await approval. (Px6).

16. According to the records of Lake County Physical Therapy, Px1, Petitioner underwent a functional capacity evaluation on June 11, 2008 performed by therapist Zubin Tantra. The following history was noted: "The patient reports that he was loading rolls of carpet in a semi-truck, when his boss used a forklift to pick up a roll, which pushed him and twisted his leg downwards and to the side and injured his right knee and twisted his body around. The patient tried to continue working for fear of losing his job. The patient worked almost an entire year as most of construction work outside is only three months. The patient stopped working one year later because he limped and could not drag his leg any more and he had gone to his doctor." The therapist noted Petitioner's employment was terminated in July 2007 and noted right knee surgery on November 14, 2007. The therapist also noted, "He was also having left shoulder pain since the beginning and was sent for physical therapy for the right shoulder after his knee surgery. Patient did not have physical therapy after knee surgery." The therapist noted Petitioner's job which involved some construction and carpeting. Petitioner worked in the summer in extreme heat conditions indoors and was exposed to fumes when demolishing drywall. He did a lot of bending, lifting, cutting and rolling carpet and carry carpet onto shoulder to truck. He had to hold fixtures overhead and lift up to 100 pounds. He did occasional outdoor work. He also set up bleachers, fixed lockers, toilets and other plumbing issues and changed lights. The therapist noted Petitioner complained of having difficulty holding his left shoulder and arm up for one to two minutes. He also complained of great difficulty up and down stairs, kneeling was very painful as was crawling and squatting.

The therapist noted that the Dictionary of Occupational Titles placed Petitioner's occupation as a General Laborer in the heavy strength category. The therapist noted that Petitioner met the strength requirements and may return to work as a General Laborer. The therapist noted that although Petitioner had excellent strength in his left shoulder and arm, he could not perform activities that required prolonged use of his arm overhead. He was unable to crouch fully and he had pain with prolonged kneeling activities. The therapist concluded, "He can return to any position in the heavy category that does not require prolonged overhead use of his left arm." The therapist recommended a work hardening program.

17. At Respondent's request, Petitioner saw Dr. Papierski on February 4, 2009 for a §12 evaluation. In his report of that date, Rx5, DepEx2, Dr. Papierski noted that Petitioner reported that in September 2005, his left shoulder began to have severe pain due to heavy lifting, some overhead. Dr. Papierski noted Petitioner reported he sustained a right knee injury on June 1, 2006 and had undergone surgery. Petitioner complained of increased right knee pain with walking up an incline. Petitioner also complained of intermittent left shoulder severe pain if he lifted up his left arm. There was no pain at rest and some stiffness. Dr. Papierski noted Petitioner reported his left shoulder symptoms began as he was required to carry a heavy tool bag

on his left shoulder. Petitioner also reported he was using a shovel or scraper to elevate carpet off the floors. Petitioner had brought the tool bag with him and Dr. Papierski noted it weighed close to the weight of a gallon of milk. Dr. Papierski reviewed Dr. Young records. Following his examination, it was Dr. Papierski's impression that Petitioner had 1) right knee chondromalacia, status post arthroscopy and 2) left shoulder rotator cuff syndrome with os acromiale and AC joint degenerative joint disease.

Dr. Papierski opined that it would appear from the medical records that Petitioner's right knee condition was causally related to the June 1, 2006 incident. Dr. Papierski opined that the chondromalacia was most likely a preexisting condition, but may have been aggravated by the June 1, 2006 incident. Dr. Papierski opined that Petitioner's left shoulder condition appeared to be degenerative in origin. Dr. Papierski opined that the activities reported by Petitioner did not appear to show any risk for the development of rotator cuff tendonitis. Dr. Papierski opined that the os acromiale was a developmental condition and not the result of any work activities. Dr. Papierski opined Petitioner's treatment was reasonable and necessary. Dr. Papierski opined Petitioner has reached maximum medical improvement for his right knee condition. Dr. Papierski opined that maximum medical improvement did not apply to the left shoulder degenerative condition as there would be ongoing degeneration and further symptoms worsening over time. Dr. Papierski noted that Petitioner demonstrated good strength and range of motion of his upper extremities and reasonably good right knee range of motion. Dr. Papierski opined Petitioner could probably function at the medium or medium heavy category and that a functional capacity evaluation might be helpful. Dr. Papierski opined there appeared to be no left arm injury for which future treatment would be needed, but there may be future treatment needed for the left arm degenerative condition. He opined that no future treatment was needed for the right knee.

18. Petitioner did not see Dr. Young again until May 8, 2009. On that date, Dr. Young reviewed the functional capacity evaluation report and noted that it was nearly normal and Petitioner had met the demands of a heavy to very heavy work load. Dr. Young noted, "Although he may be able to carry, lift, push, pull, etc, on the Functional Capacity Evaluation, this is done on a very limited timeframe and although he is able to accomplish these tasks, he is in pain and he is only able to do these for short periods of time." Dr. Young opined that Petitioner's right knee impairment was related to his work. Dr. Young opined that continuing overhead work was probably not something Petitioner would be able to tolerate in the future. Dr. Young suggested Petitioner look into vocational rehabilitation or look for lighter duty work. Dr. Young noted, "This would be involved primarily in sedentary type activities or standing and walking without significant amounts of lifting, carrying, pushing or pulling on a prolonged basis."

In a letter To Whom It May Concern dated June 10, 2009, Dr. Young noted that Petitioner was seen on May 8, 2009 after an absence of 14 months. Petitioner reported that it took him several days to recover from the functional capacity evaluation. Petitioner reported

continued right knee and left shoulder symptoms. Dr. Young opined that he did not believe that Petitioner was able to work at a heavy capacity for an 8 hour shift as a general laborer, but he may be able to perform such work activities for very short periods of time. Dr. Young opined that Petitioner's strength was good in the short term. Dr. Young opined that light labor or even a sedentary job was more consistent with his real life restrictions. (Px6).

19. Petitioner saw Dr. Young on October 13, 2009 and complained of ongoing left shoulder problems. Petitioner reported pain radiating between his neck and down into his fingers, worse with prolonged or stressful arm activities as well as difficulty sleeping. Dr. Young noted that Petitioner felt this was related to use of a shovel or scraper in the past when elevating carpeting from a floor as well as use of a heavy tool bag on his left shoulder. On left shoulder examination, Dr. Young found some tenderness in the subacromial space and over the AC joint, but Petitioner had a negative impingement sign, negative Hawkin's sign and negative drop arm sign. Forward elevation and abduction were limited at the very extremes and he had pain with overhead for 2 to 3 minutes. Dr. Young noted, "He is wondering if this is related to his work and the heavy tool bag and I have previously stated that I could not find a direct correlation to that causing his os acromiale or his shoulder pain but it could have aggravated his previously existing anatomical variant, which is the os acromiale, with heavy pressure across this area on a prolonged basis." Petitioner was to be seen as needed.

In a letter To Whom It May Concern dated November 9, 2009, Dr. Young noted Petitioner was seen on October 13, 2009 for ongoing left shoulder complaints, same as before. Dr. Young opined that it was possible that the use of this heavy tool bag on his left shoulder over a period of years, along with the use of the scrapper for elevating carpet, certainly aggravated that symptomatology in his AC joint, aggravating a chronic condition related to his work activities. (Px6).

20. At Respondent's request, Petitioner saw Dr. Papierski on January 28, 2011 for a §12 evaluation. In his report of that date, Rx5, DepEx3, Dr. Papierski noted that Petitioner reported he had not treated since his last visit because he had not gotten paid for the last 3 years. Petitioner reported he was unable to lift his left arm overhead, but later stated that he could get his left arm overhead, but could not hold it up there for any length of time. Petitioner reported that there was no left arm pain when he was not using it. He reported intermittent numbness and tingling in his left ring and middle fingers. Petitioner reported intermittent right knee pain, stiffness and swelling. Dr. Papierski noted that his impression had remained the same as before. Dr. Papierski opined there were no right knee restrictions. Dr. Papierski noted that he did not agree with Dr. Young that Petitioner was only able to perform sedentary work.

21. On November 14, 2011, Dr. Young noted that Petitioner was last seen 2½ years ago. Petitioner reported he underwent an independent medical evaluation and his pain increased intensely afterwards and for 6 months. Petitioner continued to complain of left arm pain radiating out to his fingers with any above the shoulder activity and numbness into his middle

and ring fingers. Petitioner reported having difficulty living this way and desired to proceed with further work-up even if it was out of his pocket. His right knee continued to bother him, especially with twisting, and the pain was dull and aching on a continual basis. Squatting or twisting increased his symptoms dramatically. He reported being unable to find work. Dr. Young's assessment was 1) chondromalacia; 2) rotator cuff capsule sprain and strain. Dr. Young opined that Petitioner may be suffering from cervical radiculopathy and ordered a left upper extremity EMG.

A left upper extremity EMG was performed by Dr. Schneider on December 14, 2011 and his assessment was left carpal tunnel syndrome. On December 20, 2011, Dr. Young reviewed the EMG and explained to Petitioner that occasionally a patient will have symptoms radiating to the shoulder from the carpal tunnel. Dr. Young could not assure Petitioner that performing a carpal tunnel release would alleviate his left shoulder symptoms. Dr. Young noted that there was no evidence of cervical radiculopathy. Petitioner was to follow-up as needed. (Px6).

22. In his deposition taken on June 13, 2012, Px12, Dr. Young testified he is a board certified orthopedic surgeon and recited his records, which are noted above. Dr. Young testified that the restrictions he issued on April 3, 2007 were no lifting greater than 50 pounds (Dp 10). On June 11, 2007, his restrictions were no lifting greater than 50 pounds, no squatting, no crawling, no kneeling, no pushing, no pulling or climbing on ladders or scaffolds and no carpet removal (Dp 13). Dr. Young opined that trauma can aggravate or exacerbate chondromalacia and synovitis. Dr. Young opined it is reasonable that the chondromalacia and synovitis for which he performed surgery on November 14, 2007 could or might have been caused or aggravated by the June 1, 2006 injury Petitioner suffered (Tr 16). In describing an os acromiale, Dr. Young explained that in the vast majority of patients, when they are very young the acromion developes from a couple of different pieces of bone which coalesce together and form solid bone. However, in a certain percentage of people that will not happen and an os acromiale will stay as a separate piece, which is hooked together by a very dense cartilage layer, but it is actually a separate bone. There is not really a joint there and that area of cartilaginous attachment is not as resilient as bone and he opined that it can be injured (Dp 19-20). Dr. Young opined that Petitioner's work activities could or might have aggravated the degenerative changes in his AC joint and this type of injury is more likely to be repetitive (Dp 23). Dr. Young opined that the os acromiale was aggravated by Petitioner's work activities (Dp 23). The aggravation could be either a one-time event or a repetitive injury and Dr. Young thought it was probably more repetitive in nature (Dp 24). Dr. Young opined that the rotator cuff tendonopathy certainly could be aggravated by Petitioner's work activities, which were repetitive in nature (Dp 24). Dr. Young opined that all three above can be asymptomatic and repetitive activity can cause them to then become symptomatic (Dp 25).

Dr. Young opined that the functional capacity evaluator's conclusion that Petitioner was fit to work at any level was ridiculous. He opined that Petitioner could do things for a short period, but that is different from doing them for 8 hours a day (Dp 27). Dr. Young opined

Petitioner cannot perform heavy work (Dp 33). Dr. Young opined that the restrictions for Petitioner's left shoulder and right knee are related to the work injuries discussed (Dp 34). On June 9, 2009 his restrictions were no squatting, crawling or kneeling, no standing greater than 30 minutes and no climbing ladders or scaffolds (Dp 34). Dr. Young indicated that the left upper extremity EMG ruled out cervical radiculopathy (Dp 38). He opined his charges were reasonable and necessary (Dp 39).

On cross-examination, Dr. Young testified he did not know how often Petitioner had the tool bag on his left shoulder (Dp 48). Dr. Young noted that at least a portion of Petitioner's job was getting worn carpeting off the floor with a shovel or scraper which involved pretty heavy pushing and repetitive shoveling against adhesed carpet to try and break up the adhesion to the floor (Dp 47). Dr. Young's opinions regarding the left shoulder were based partly on Petitioner constantly having the tool bag on his left shoulder and partly on the jamming of tools to elevate the carpet (Dp 48). He did not know how heavy the tool bag was (Dp 49). He imagined that if his left shoulder was hurting, Petitioner could have carried the tool bag on his right shoulder (Dp 49). Dr. Young opined that Petitioner's left shoulder complaints were caused or aggravated by carrying a tool bag on his left shoulder because of the added weight pulling across his AC joint and os acromiale on a repetitive basis (Dp 50). During the right knee surgery, no meniscal tear was found (Dp 53). Dr. Young opined that as people age, they have a tendency to have chondromalacia (Dp 53). Chondromalacia can be the result of a traumatic event (Dp 54). Synovitis can be developmental (Dp 55). Dr. Young opined that Petitioner is unable to do the functional capacity evaluation activities on a prolonged basis (Dp 61). Dr. Young did not know when Petitioner reported his knee injury to his employer (Dp 72). As far as he knows, Petitioner did not have medical treatment before he saw him on April 3, 2007 (Dp 73). Dr. Young opined that he believes Petitioner is employable (Dp 83). Dr. Young opined Petitioner does not need any more medical treatment and nothing was planned at that time (Dp 84). The last time Dr. Young saw Petitioner was on January 17, 2012 for complaints of left carpal tunnel syndrome (Dp 84-85).

On re-direct examination, Dr. Young opined that Petitioner reached maximum medical improvement for his left shoulder and right knee on May 8, 2009 (Dp 88). The left shoulder condition could have just worsened for that entire year and this March 27, 2007 incident was the one that brought Petitioner to him (Dp 93). On re-cross examination, Dr. Young testified that Petitioner did not report that he had sustained a right knee injury or left shoulder injury on March 27, 2007 (Dp 95-96).

23. In his deposition taken on March 1, 2013, Rx5, Dr. Papierski testified that he is a board certified orthopedic surgeon and recited his reports, which are noted above. Dr. Papierski was shown the June 11, 2008 functional capacity evaluation report and he reviewed same (Dp 19). Dr. Papierski agreed with the functional capacity evaluation report findings (Dp 20).

On cross-examination, Dr. Papierski testified that Petitioner did give March 27, 2007 as a date of onset or injury (Dp 21). This day was the first time he had reviewed the functional capacity evaluation report (Dp 22-23). Dr. Papierski testified that his opinions were not based on the functional capacity evaluation report (Dp 23). Dr. Papierski did not know details as to Petitioner's scraper use (Dp 43-44).

24. Petitioner submitted the following medical bills which were admitted into evidence:
-Px5: Lake Zurich Family Treatment Center 11-9-07. Charges: $330.00. Petitioner paid: $330.00. $0 balance due.
-Px3: Advocate Good Shepherd Hospital 11-14-07. Charges: $8,779.00. Workers' compensation paid: $2,115.10. First Health insurance paid: $957.55. Gallagher Basset paid: $5,706.35. $0 balance due.
-Px4: Barrington Anesthesia 11-14-07. Charges: $900.00. Blue Cross/Blue Shield paid: $336.00. Contractual Discount: $420.00. Petitioner paid: $144.00. $0 balance due.
-Px2: Barrington Rehabilitation and Sports Medicine. Charges: $1,802.00. Insurance paid: $491.17. Petitioner paid: $140.00. Adjustments: $1,170.83. $0 balance due.
-Px1: Lake County Physical Therapy. Charges: $1,400.00. Payments: $1,119.68. Adjustments: $280.32. $0 balance due.
-Px9: Prescription bills. Charges: $10.00.

25. Petitioner submitted job search records and these were admitted into evidence as Px13. Petitioner submitted Leave of Absence packet and this was admitted into evidence as Px15. Petitioner submitted vacation timeslips and these were admitted into evidence as Px17, which show that Petitioner was on vacation from the week ending July 28, 2006 through the week ending August 11, 2006. The Commission has reviewed the above.

26. Respondent submitted the Application for Adjustment of Claim for dismissed case 07 WC 19685 and this was admitted into evidence as Rx1. Respondent submitted the Application for Adjustment of Claim for case 07 WC 19686 and this was admitted into evidence as Rx2. Respondent submitted the Application for Adjustment of Claim for case 07 WC 19769 and this was admitted into evidence as Rx3. Respondent submitted the curriculum vitae of David Patsavas and this was admitted into evidence as Rx4. The Commission has reviewed the above.

Based on the record as a whole, the Commission reverses the Decision of the Arbitrator for case 07 WC 19686 finding that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on June 1, 2006, failed to prove he gave timely notice to Respondent and failed to prove that a causal relationship exists and denies Petitioner's claim. The Commission affirms the Decision of the Arbitrator for case 07 WC 19769.

In case 07 WC 19686, Petitioner testified to an unwitnessed occurrence on June 1, 2006 when his right knee was pinned between two rolls of carpet as he was in a delivery truck. However, the Commission finds that Petitioner failed to prove he sustained an injury to his right knee during this event. Although he testified to being in a lot of pain, Petitioner did not treat immediately after this occurrence and not until April 3, 2007, 10 months later. Petitioner continued to work at full duty after June 1, 2006 and performed the same duties as he had before that date. Petitioner was on vacation from the week ending July 28, 2006 through the week ending August 11, 2006. Following his vacation, Petitioner returned to and performed those same full duties. Petitioner did not seek treatment until April 3, 2007 when he saw Dr. Young. Petitioner reported to Dr. Young that he did not report this occurrence because his boss was involved. Yet, Petitioner testified he told Jim Manago and Calvin Carter about the occurrence on the day it happened. There was no accident reporting paperwork done. Petitioner did not call Jim Manago, Calvin Carter or Bruce Davis to testify. Both Dr. Young and §12 Dr. Papierski opine causation for the June 1, 2006 occurrence, but this is based on Petitioner's reports to them.

Regarding case 07 WC 19769, the Commission finds there is a total lack of proof for the left shoulder claim. The evidence indicates no accident occurred on March 27, 2007. Petitioner generally argued repetitive trauma in carrying a tool bag on his left shoulder for 4½ years, but did not testify to any details, other than the tool bag weighed about 10 pounds. The Commission further finds that Petitioner failed to prove he gave Respondent notice of any accidental injury to his left shoulder. Petitioner testified that he told Bruce Davis he could not take it anymore and he had to see a doctor. Petitioner also testified that he had a conversation with Bruce Davis on March 27, 2007 and that he told him about his left shoulder and right knee, but then testified this conversation took place on April 3, 2007. Petitioner did not call Bruce Davis to testify. When he saw Dr. Young on April 3, 2007, Petitioner reported he had symptoms in his left shoulder and elbow for about one year. Petitioner did not testify that he had notified anyone at Respondent about those symptoms during that period.

IT IS THEREFORE ORDERED BY THE COMMISSION that in case 07 WC 19686 since Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on June 1, 2006 and since he failed to prove a causal relationship exists, his claim for compensation is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that in case 07 WC 19769 since Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on March 27, 2007 and since he failed to prove a causal relationship exists, his claim for compensation is hereby denied.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 19 2014
MB/maw
o01/16/14
43

Mario Basurto

Michael J. Brennan

David L. Gore

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Causal Connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jordan Cole,

Petitioner,

vs.

NO: 10 WC 28458, 10 WC 28459

14IWCC0195

Tri County Coal, LLC,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability and permanent partial disability and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of causal connection as stated below.

Petitioner, a 23-year-old coal mine laborer, filed Applications for Adjustment of Claim alleging accidental injuries to his low back on October 28, 2009 and July 13, 2010. The Arbitrator found that Petitioner's current condition of ill-being is causally related to the injuries sustained. The Arbitrator relied on Petitioner's testimony that his symptoms dramatically increased after each accident – despite the evidence that Petitioner was already symptomatic from a pre-existing condition prior to each accident. The Arbitrator concluded that each accident was a causal factor in Petitioner's need for medical treatment, lost time and disability. The Arbitrator awarded Petitioner permanent partial disability benefits representing 20% of the person as a whole. On review, Respondent argues that the Arbitrator's decision should be reversed in its entirety. Petitioner seeks additional permanent partial disability benefits.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Petitioner testified that on October 28, 2009 he was operating a roof-bolting machine,

drilling eight-foot bolts into the mine ceiling. While Petitioner held a bolt in place, using both hands, it "kicked sideways" from the bolting machine, causing Petitioner to twist his back. He experienced immediate pain in his back and told his coworker and supervisor what happened. Petitioner continued his shift and did not seek medical attention. (T. 20-22)

2. Petitioner offered the records of chiropractor Lisa Hart as Petitioner's exhibit 18. On October 30, 2009, Petitioner completed a questionnaire at Dr. Hart's office, where he had been a former patient. He noted a history of chiropractic treatment for the "same reason" but sought current treatment because the "pain got bad in the last few days." Petitioner indicated that his current symptoms began on "10-5." Dr. Hart's records note that Petitioner "works in coal mine lifting repeatedly & bending all day long" but that the current onset of symptoms began on October 5, 2009. There is no mention in the records of a specific accident or injury. Petitioner complained to Dr. Hart of pain in his low back and both legs, especially the left leg.

3. Respondent offered pre-accident records from Dr. Hart's office as Respondent's exhibit 1. The records reflect one chiropractic visit for complaints of sharp low back pain in June of 2001 and two chiropractic visits for bilateral hip pain occurring in April and May of 2005. Petitioner testified that he was very athletic when he was younger and developed back pain from lifting weights. (T. 45-46)

4. Petitioner returned to Dr. Hart for seven additional chiropractic sessions in November of 2009. He showed improvement with respect to back pain and left leg pain, with the left leg pain resolving completely by the end of November. He did, however, begin to complain of right leg pain. Dr. Hart noted that Petitioner was working on his farm. A November 23, 2009 lumbar x-ray revealed mild degenerative changes and an MRI was recommended for further evaluation. At Petitioner's final visit with Dr. Hart on November 30, 2009, Petitioner continued to complain of back pain of fluctuating levels of severity. He believed that the pain was localizing to the right of his lower back and Dr. Hart ordered an MRI of the lumbar spine. (PX 18)

5. There followed a seven-month gap in treatment where Petitioner continued to work full duty. Petitioner testified that he believed he no longer needed any treatment. (T. 25) The records show that Dr. Hart's office attempted to communicate with Petitioner for follow-up but he did not return any calls. Accordingly, the MRI scheduled for December 15, 2009 was cancelled. (PX 18)

6. On July 5, 2010, Petitioner went from his home to the emergency room at Jersey Community Hospital with complaints of severe low back pain. Petitioner reported that he was getting married several days later. He denied any inciting incident or injury. A lumbar x-ray showed a very minimal facet hypertrophy at the lower lumbar levels. The radiologist recommended an MRI if clinical findings suggest a disc bulge. Petitioner was diagnosed with left sciatica and treated with pain medication. (PX 4)

7. On July 9, 2010, Petitioner was seen by his primary care physician, Dr. Mapue. Petitioner complained of low back and left leg pain radiating to his foot, increasing in severity for two to three weeks, with additional left foot numbness. Petitioner stated that he had been in a work-related accident eight or nine months earlier. He told Dr. Mapue that he had previous

chiropractic treatment and was recently seen in the emergency room. Dr. Mapue diagnosed acute or chronic low back pain and sciatica and ordered an MRI. (PX 5)

Petitioner was married on July 10, 2010 and returned to work on July 12, 2010. Petitioner testified that he went to the emergency room on July 5, 2010 because he was concerned that his back pain would interfere with his wedding. (T. 28)

8. On July 13, 2010, one day after Petitioner returned to work, Petitioner alleged that he sustained a second accident while shoveling lightweight coal debris onto a conveyor belt. He testified that he felt a sudden pain and burning sensation from his lower back down his left leg, worse than any pain he had ever previously experienced. (T. 33) He testified that he was transported via ambulance to the emergency room, however no ambulance records appear in evidence. Petitioner arrived at the Memorial Medical Center emergency room with complaints of back pain with left leg pain and numbness. The emergency room records note that Petitioner worked in a mine and also performed welding and grinding work on a farm. Petitioner gave a history of feeling "something pull" in his lower back while shoveling at work. He stated that an MRI was already pending from an earlier injury. Petitioner's acute pain was treated with medication. An MRI revealed a large, left-sided disc herniation at L4-5. Petitioner was discharged from the emergency room with a diagnosis of sciatica. He was prescribed narcotic pain medications and anti-inflammatories. (PX 2)

9. On July 16, 2010, Petitioner returned to Dr. Mapue. He reported that his symptoms had not improved since he left the emergency room on July 13, 2010. A description of the October 28, 2009 accident appears in the records for the first time. Petitioner stated that while roof-bolting on October 28, 2009 he felt a pop on the left side of his lower back and made an incident report. He stated that his symptoms of low back pain with left-sided radiation would come and that chiropractic treatment gave him partial relief. Dr. Mapue referred petitioner to Dr. VanFleet for further evaluation. Several days later on July 19, 2010 Dr. Mapue wrote an excuse slip taking Petitioner off of work. (PX 5)

10. Petitioner filed two Applications for Adjustment of Claim on July 26, 2010. Case number 10 WC 28458 alleges that Petitioner twisted his back trying to get a bolt into a hole on October 28, 2009. Case number 10 WC 28459 alleges that Petitioner injured his low back "shoveling rocks onto a conveyor belt" on July 13, 2010.

11. On July 28, 2010, Petitioner was examined by Dr. Russell at Springfield Clinic. Petitioner stated that he hurt his back on October 28, 2009 and then reinjured his back three weeks before seeing Dr. Russell. Petitioner complained of a burning pain in his left foot and numbness with walking. He reported that he had an epidural steroid injection one month earlier and some additional chiropractic treatment without improvement. We note that there are no records corresponding to an epidural steroid injection or any chiropractic treatment in 2010.

Dr. Russell recommended surgery. Due to the large size of the fragment seen on the MRI, Dr. Russell did not believe that Petitioner's symptoms would resolve with any further conservative treatment. Dr. Russell took Petitioner off of work. Petitioner did not tell Dr. Russell that he had been in the emergency room, had seen his primary care physician and received an

order for an MRI in the week prior to July 13, 2010. Dr. Russell did not offer a causal connection opinion. (PX 7)

12. On August 13, 2010, Petitioner was examined by Dr. VanFleet. Petitioner's medical history questionnaire notes a history of low back pain from "10-28-09 running piece of equipment in mine twisted back pain started then 7-13-10 pain worsened when at work shoveling on belt twisted again & pain worsened." Petitioner claimed to have been unable to work or perform normal household duties since July 13, 2010. A pain drawing completed by Petitioner indicates low back aching and stabbing pain with anterior left leg shooting pain and left foot numbness and tingling. Notably, Petitioner failed to mention the October 5, 2009 episode, his emergency room treatment on July 5, 2010 or being seen by Dr. Mapue on July 9, 2010. Reviewing Petitioner's MRI, Dr. VanFleet identified a sequestered disc fragment posterior to the L4-5 disc space on the left side. Dr. VanFleet recommended an L4-5 hemilaminotomy, partial medial facetectomy and discectomy. (PX 2) Dr. VanFleet issued an excuse slip taking Petitioner off of work pending surgery. (PX 3)

On August 17, 2010 Dr. VanFleet performed a L4-5 hemilaminotomy, partial medial facetectomy and discectomy. The operative report states that Dr. VanFleet removed two large sequestered fragments from the spinal canal. Petitioner followed up with Dr. VanFleet on September 1, 2010 and the doctor noted Petitioner was doing "exceedingly well." On October 7, 2010 Petitioner began post-operative physical therapy at Boyd Healthcare Service. He was discharged after twelve sessions with no residual back or leg pain or foot tingling, only mild aching in the low back and left buttock. Dr. VanFleet released Petitioner to return to work without restrictions effective November 22, 2010. (PX 2)

13. On October 10, 2011, Dr. Coyle performed a record review at the request of Respondent. Dr. Coyle was skeptical about Petitioner's history in the context of a workers' compensation claim, noting the lack of documentary evidence corresponding to the October 28, 2009 accident, no explanation for the existence of the October 5, 2009 onset date in the records, the long delay in filing a claim for the October 28, 2009 accident, and the evidence in the records that the same problems Petitioner alleged on July 13, 2010 were present prior to that date. Dr. Cole opined that "based on the objective evidence in the medical record, the symptoms may have flared up on the two occasions at work but were due to pathology which already preexisted the work incidents. This is documented by the chiropractor, Dr. Hart, and Mr. Cole's primary physician, Dr. Mapue, as well as the ER records." Dr. Coyle believed that the MRI findings were consistent with a chronic condition. (RX 3)

14. Dr. VanFleet testified via deposition on December 14, 2011. Dr. VanFleet explained that a sequestration is a free fragment within the spinal cord, and that the surgical findings were consistent with Petitioner's left-sided pain complaints. Dr. VanFleet testified that Petitioner had a good recovery following surgery and has not returned with any further complaints since his release to return to full duty work. Petitioner gave Dr. VanFleet a history of two work-related accidents with injuries to his low back. Therefore, Dr. VanFleet opined that the accidents were causally related to the need for surgery. Dr. VanFleet believed that the history was consistent with the type of pathology present in Petitioner's lumbar spine, and he agreed that if Petitioner heard a pop in his low back on July 13, 2010 it could have been the nucleus extruding through

the annulus. We note that Petitioner did not give a history to the emergency room of hearing a pop in his low back on July 13, 2010. Dr. VanFleet believed the large fragment found in the spinal canal was a recent rather than longstanding pathology due to the tendency of fragments to re-absorb over time.

On cross-examination, Dr. VanFleet agreed that Petitioner had some degree of pre-existing degeneration. He could not say when the disc herniation occurred, only that he believed it must have occurred within the six months prior to the August 17, 2010 surgery.

Dr. VanFleet agreed that if the history he received was either incorrect or incomplete his opinions could change. He was not aware of Petitioner's chiropractic treatment before the first accident or that Petitioner went to the emergency room and to his primary care doctor for severe low back pain before the second accident. Dr. VanFleet agreed that additional information about medical treatment sought by Petitioner would be important in determining causation. (PX 8)

After reviewing all of the evidence, we reverse the decision of the Arbitrator and find that Petitioner failed to prove his current condition of ill-being is causally related to the accidents alleged. We note that there is no evidence to corroborate Petitioner's testimony with respect to the first accident on October 28, 2009. Not only is it absent from Dr. Hart's examination records from October 30, 2009 to November 30, 2009, but Petitioner himself did not report it on his handwritten patient questionnaire when he first sought treatment, only two days after the alleged accident. Instead, he reported an onset of pain with no trauma on a different date weeks earlier, October 5, 2009; a fact he did not deny at hearing. (T. 48-49; PX 18)

Petitioner abruptly stopped communicating with Dr. Hart's office at the end of November 2009, causing Dr. Hart to cancel the December 15, 2009 lumbar MRI. Petitioner sought no further treatment until July 5, 2010 and continued to work full duty. Although Petitioner testified that he stopped seeing Dr. Hart because he did not feel that he needed treatment, Dr. Hart's note from November 30, 2009 reflects that Petitioner had been experiencing "10/10" pain just one day earlier. (PX 18)

With respect to the July 13, 2010 accident, while the occurrence of a lifting incident is partially corroborated by the emergency room records from Memorial Medical Center, the preponderance of the evidence shows that Petitioner was already suffering from an acute episode of back pain and that the July 13, 2010 accident did not cause Petitioner to require lumbar surgery. In the weeks prior to July 13, 2010, during a period of time where Petitioner was actually on vacation from work, the records clearly show that Petitioner was suffering from severe back pain. He visited the emergency room on July 5, 2010 in so much pain that he was concerned about standing at his wedding. Petitioner was prescribed narcotic painkillers and Dr. Mapue ordered an MRI several days later. There is no evidence that Petitioner's condition resolved by the time he returned to work on July 12, 2010. We find insufficient evidence to prove that the July 13, 2010 incident is a tenable causal factor in Petitioner's current condition; Petitioner's subjective history alone is not reliable.

In conclusion, we find that Petitioner failed to meet his burden of proof on the issue of causal connection between each accident and his current condition of ill-being. Dr. VanFleet's

14IWCC0195

testimony is not persuasive on the issue of causation where he was unaware of significant medical history. Petitioner did not deny that he failed to tell Dr. VanFleet about pre-existing symptoms and periods of treatment. In contrast, Dr. Coyle reviewed all of Petitioner's records before concluding that the same condition Petitioner alleged to have occurred on each date of accident was already in progress prior to each accident. Petitioner's failure to disclose his medical history, and the contradictions between the record and Petitioner's testimony, render Petitioner's claims unreliable. Even if Petitioner's testimony is accepted in its entirety, the preponderance of the evidence shows that the accidents could have caused no more than temporary aggravations of his pre-existing condition.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed January 14, 2013 is hereby reversed and Petitioner's claims for benefits are denied.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 19 2014
RWW/plv
o-1/28/14
46

Ruth W. White

Charles J. DeVriendt

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COLE, JORDAN
Employee/Petitioner

Case# **10WC028458**

10WC028459

TRI COUNTY COAL LLC
Employer/Respondent

14IWCC0195

On 1/14/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0895 MORMINO VELLOFF EDMONDS & SNIDER PC
SAMUEL A MORMINO JR
3517 COLLEGE AVE
ALTON, IL 62002

0332 LIVINGSTONE MUELLER ET AL
DENNIS S O'BRIEN
620 E EDWARDS ST PO BOX 335
SPRINGFIELD, IL 62705

14IWCC0195

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jordan Cole
Employee/Petitioner

v.

Tri County Coal, L.L.C.
Employer/Respondent

Case # 10 WC 028458

Consolidated cases: 10-WC-028459

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **11/13/12**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **10/28/09 & 7/13/10**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury of 7/13/10, Petitioner earned $**41,088.60**; the average weekly wage was $**810.20**.

On the date of accident, Petitioner was **23** years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall pay the Petitioner temporary total disability of **$540.13** a week for **18 4/7** weeks, commencing **7/14/10** through **11/21/10** in the amount of **$10.030.99** as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$7.371.43** for temporary total disability benefits that have been paid.

ORDER

Respondent shall pay Petitioner the sum of $486.12 a week for a further period of 100 weeks as provided in Section 8(d)2 of the Act because the injuries sustained caused a loss of 20% of a person as a whole.

Respondent shall pay Petitioner temporary total disability benefits of $540.13 a week for 18 4/7 weeks from 7/14/10 through 11/21/10, which is the period of temporary total disability for which compensation is payable. Respondent is allowed a credit of $7,371.43 under Section 8(j) of the Act for group, non-occupational disability benefits.

Respondent shall pay the further sums for necessary medical services, as provided in Section 8(a) of the Act, as follows: (a) Jersey Community Hospital $1,194; (b) Radiologic Physicians $62; (c) Dr. Mapue $156; (d) Memorial Medical Center $3,238.20; (e) Clinical Radiologist $385.50; (f) Dr. Brain Russell $340; (g) Dr. Timothy Vanfleet $13,388; (h) Associate Anesthesia Springfield $1,395; and (i) Orthopedic Center of Illinois $8,857, to the extent required by the Fee Schedule, Section 8.2 of the Act.

Respondent provided Petitioner's medical, surgical and hospital benefits under its group plan for Petitioner's medical expenses incurred as a result of his work injury. Respondent shall keep Petitioner safe and harmless from any and all claims or liabilities that may be made against by reason of having received such benefits to the extent of such credit as provided in Section 8(j) of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator D. Ryan McCarthy Date Jan. 8, 2013

The Arbitrator Finds the Following Facts:

The parties arbitrated these claims by consolidation, and the Arbitrator will issue one decision covering both claims.

Petitioner worked as a coalminer/roof bolter for the Respondent for approximately 1 year prior to October 28, 2009. He continued to work for the Respondent through July 13, 2010 and then to the present. Petitioner testified that in the month preceding the October 28, 2009 accident, he worked predominantly as a roof bolter and was required to operate a machine that inserted a support system in the roof of the mine. His job involved following a machine that drilled holes into the roof of the mine so that 6 to 8 foot bolts with metal plates could be inserted into the hole and affixed to the roof of the mine in order to provide support for the roof as a mining operation continued. He and a coworker were required to follow the machine, remove 6 to 8 foot approximately 1 inch thick roof bolts, with 4 by 12 inch metal plates attached, from a supply bin. He positioned the bolt into the predrilled hole and forced them up through the hole, placed them on a chuck on the machine and allowed the machine to drill them in place.

On October 28, 2009 Petitioner and a coworker were placing 8-foot bolts into the roof of the mine near an intersection of pathways. The roof at that point was less than 6 foot in height requiring Petitioner to bend the roof bolt as it forced upward into the predrilled hole. From a standing position, he was forcing the 8 foot rod into the hole, with a downward motion with both hands on the rod, he felt a sudden sharp, intense, stabbing pain in his back radiating into his left hip and thigh. He stopped and informed his supervisor of the injury and an accident report was prepared. Petitioner testified that he was able to finish his shift with difficulty.

Petitioner first sought medical treatment from Dr. Lisa Hart, D.C. on October 30, 2010. Dr. Hart's records (PE 18) reveal that Jordan Cole indicated on the intake questionnaire that he had suffered some back pain for a few weeks prior but that he was having sharp pain down both legs with pain constantly down the left leg to his thigh, which was worse over the last few days. The records indicate that on Wednesday (10/28), the date of the incident, he reported his pain as an 11 on a 10-point scale. Following Dr. Hart's examination of him he continued to work continuously and received conservative care from her through November 30, 2009. He experienced some improvement during the time he visited with Dr. Hart. When he last saw Dr. Hart, he still reported pain at a "6" level, with pain at the level of "10" on the previous day. Dr. Hart at that time recommended an MRI. Petitioner testified that he was able to work, although not symptom free, and decided to stop chiropractic care.

Petitioner continued to work fulltime through July 13, 2010. He reported that his back and left buttock pain would wax and wane with varying intensity while he continued to work fulltime in the mine as a roof bolter. Petitioner testified that he sought treatment from the emergency room at Jersey Community Hospital where he received an injection for low back pain on July 5, 2010. He reported back pain, and was diagnosed with left sciatica. He received injections and oral medications. He followed up with his family physician, Dr. Mapue on July 9, 2010. His office note contains a history that the Petitioner had an injury to his lower back 8 to 9 months prior, and that he noticed a worsening of his lower back symptoms, with radiation to his left leg and foot with numbness over the past 2 to 3 weeks. He indicated the reason for his visits to the emergency room and to Dr. Mapue was because he was getting married on July 10, 2010 and wanted some temporary relief for his ongoing back pain that started on October 28, 2009. He had scheduled his wedding during the mine shutdown and returned to work on July 12th and worked a full shift as a laborer, shoveling coal debris.

On July 13th at approximately 10:00, while shoveling debris onto a conveyor belt, he felt a "pop" and a sharp sudden shooting pain down his left leg that he described as intensely cold then intensely hot, driving him to his knees. This occurred when he was using a broad bladed utility shovel, scooping the debris, twisting at the waist and throwing it onto the conveyor belt approximately 36 inches high. He was attended to by the plant manager

who happened to drive by at that time. The plant manager loaded him onto a transportation vehicle, transported him out of the mine and then summoned an ambulance. The ambulance rushed him to Memorial Medical Center where he was treated in the emergency room. An MRI that was taken on July 13 revealed a large sequestrated herniated disc at L4-5. He was taken off work immediately and instructed to follow up with his own physician.

At the request of his employer he saw Dr. Brian Russell an orthopedic surgeon on July 28, 2010, who diagnosed a large herniation at L4-5, significantly compromising the thecal sac in the exiting nerve root. Dr. Russell recommended surgery. (PE 7). His family physician, Dr. Mapue recommended an orthopedic surgeon, Dr. Timothy Van Fleet. Dr. Van Fleet reviewed the MRI scan, which demonstrated a sequestrated fragment of the disc posterior to the body of the L5 from the L4-5 disc space on the left side. (PE 2). As a result of that, Dr. Van Fleet scheduled and performed an L4-5 hemilaminotomy, partial medial facetectomy and a discectomy operation. That surgery was performed on January 13, 2011. (PE 2). His operative report describes "sequestrated fragments of disc in the canal that were removed; two big pieces were removed at this time". (PE 2). When describing the herniated disc that was revealed on the MRI scan, both Dr. Russell, Dr. Van Fleet, the orthopedic surgeon who performed surgery, and Dr. Coyle, who performed the records review at the request of the Respondent indicate that the MRI taken on January 13, 2010 revealed the disc herniation was "large". Coyle described the herniation at that level as "very large and is occluding the left half of the spinal canal at this level". (RE 3). Dr. Russell indicated that it was a large herniation significantly compromising the thecal sac in the exiting nerve root". (PE 7). Dr. Van Fleet described it as sequestrated and a very large fragment. (PE 8). He further observed interoperatively that it was two big pieces (Page 18) and that the fragments encroached upon the spinal canal and the nerve root both. (Page 10). Dr. Van Fleet described sequestration as a condition in which the nucleus pulposus ruptures through the annulus extending beyond the confines of the disc itself so that it is no longer continuous with the disc space. (Page 6).

The Petitioner testified that while he was shoveling coal on July 13, 2010 he had to lift the shovel to waste high position and then twist at the waste shoveling onto a conveyor belt, which was 36 inches in height. He indicated that he felt a **"pop"**, he felt immediate sharp pain extended down his leg to his foot that he describes first as intensely cold then intensely hot. After having reviewed the MRI, then actually observing the disc when he removed the two disc fragments from the Petitioner, Dr. Van Fleet testified that "it was very unlikely that that large fragment would have been present for 6 months". Dr. Van Fleet testified that in most instances large fragments like that are inclined to reabsorb within the body.

Until the July 13, 2010 incident, the Petitioner was able to continue his work as a roof bolter and laborer for Respondent. The work Petitioner engaged in was extremely physical and heavy. It was only until the July 13, 2010 shoveling accident that the Petitioner was rendered unable to work because of his increased back pain and severe and debilitating radiating pain down to his left foot. The acute onset of his symptoms, were so severe that he had to be transported by ambulance to the hospital on an emergency basis. All physicians who have reviewed the MRI agree that the herniated disc was very large.

Dr. Van Fleet continued to follow Jordan after the surgery. He saw marked improvement in his condition. Petitioner returned to work following his release from Dr. Van Fleet on November 22, 2010. Petitioner has resumed work as a roof bolter for Respondent and continues to work fulltime. Petitioner testified that he continues to suffer from back pain and radiation of pain to his left lower extremity. He experiences weakness in his low back and leg especially after exertion and the heavy manual labor required at work.

Therefore the Arbitrator concludes:

The Petitioner sustained a lumbar disc injury on October 28, 2009 as result of bending and twisting while applying a roof bolt while working as a laborer in Respondent's mine. Petitioner sustained further injury to the

the L4-5 disc and an aggravation of his pre-existing condition on July 13, 2010 while shoveling the coal onto a conveyor belt. As a result of the injuries on October 28, 2009 and then on July 13, 2010, the Petitioner suffered a sequestrated herniated disc at L4-5 necessitating an L4-5 hemilaminotomy and partial medial facetectomy and a discectomy operation.

An accident need not be the sole or even principal cause of an injury to be compensable. As long as it is a cause, the resulting treatment, lost time and disability are the Respondent's responsibility.

Here you have a twenty-five year old roof bolter performing heavy physical work inside a coal mine. While he had some lumbar pain prior to October 28, 2009, he had an accepted accident resulting in lower back pain radiating down the left leg. When seen by his chiropractor two days later, he described sharp pain down both legs, the left greater than the right. He was treated on a regular basis for the next month. At his final visit on November 30, he was still in pain. His chiropractor, Dr. Hart, then recommended an MRI.

The Petitioner elected to keep working and not have the test. He testified that he was never symptom free, and that is essentially what he told Dr. Mapue, his family doctor, and Dr. Van Fleet, his surgeon. On July 9, 2010, he told Dr. Mapue that his symptoms were worse over the past two to three weeks. He told Dr. Van Fleet that he was never pain free following his initial accident in October. (PX 8 at 6) On July 13, he injured his back shoveling debris onto a conveyor belt. He heard a pop and his symptoms intensified. He reported it immediately, and was driven to the hospital by his plant manager.

Dr. Van Fleet testified that he found a disc fragment on a nerve root at L4-5 to the left. He opined that this fragment could have pushed through the annulus when the Petitioner was shoveling on the 13th. Even if the fragment were already present, as the Respondent argues, the event on July 13 could still be causally connected to the Petitioner's condition. His symptoms clearly increased dramatically that day.

While there may be other causes relating to the Petitioner's lumbar injuries, it is clear by his symptoms provided to his doctors, the chain of events set forth above, and Dr. Van Fleet's testimony, that these two accidents were also causative factors. As such, the resulting damages are the Respondent's responsibility.

All medical services provided by the following providers: (a) Jersey Community Hospital $1,194; (b) Radiologic Physicians $62; (c) Dr. Mapue $156; (d) Memorial Medical Center $3,238.20; (e) Clinical Radiologist $385.50; (f) Dr. Brain Russell $340; (g) Dr. Timothy Vanfleet $13,388; (h) Associate Anesthesia Springfield $1,395; and (i) Orthopedic Center of Illinois $8,857 were reasonable and necessary. All medical expenses have been paid by the Respondent's provided group health plan for which the Respondent should receive credit pursuant to Section 8(j). Respondent is further order to hold Petitioner harmless under Section 8(j) for medical bills paid by its group carriers.

Respondent shall pay Petitioner temporary total disability benefits of $540.13 a week for 18 4/7 weeks from 7/14/10 through 11/21/10 in the amount of $10,030.99, which is the period of temporary total disability for which compensation is payable. Respondent is allowed a credit of $7,371.43 under Section 8(j) of the Act for group, non-occupational disability benefits.

The Petitioner was released without restrictions by Dr. Van Fleet on November 22, 2010. He continues to perform his regular work for the Respondent, and has had no further medical treatment for his lumbar injury. He testified that his lower back is stiff and that occasionally at work when he stands or sits for long periods he notices pain down the left leg. The Arbitrator finds that the injuries have caused a loss of 20% Person As A Whole to the Petitioner.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nikea Venson,

Petitioner,

vs.

NO. 11 WC 36553

14IWCC0196

West Suburban Nursing & Rehab,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 13, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

14IWCC0196

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 1 2014
MPL/sj
o-01/22/2014
352

Michael P. Latz

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR
/8(a)

VENSON, NIKEA
Employee/Petitioner

Case# 11WC036553

WEST SUBURBAN NURSING & REHAB
Employer/Respondent

14IWCC0196

On 3/13/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0208 GALLIANI DOELL & COZZI LTD
ROBERT J COZZI
20 N CLARK ST SUITE 1800
CHICAGO, IL 60602

14IWCC0196

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

Nikea Venson,
Employee/Petitioner

v.

West Suburban Nursing & Rehab,
Employer/Respondent

Case # **11** WC **36553**

Consolidated cases: **none**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The Arbitrator notes that this is a Wheaton case, but that by agreement of the parties the matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Chicago**, on **12/20/12**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **6/21/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$16,761.16**; the average weekly wage was **$322.33**.

On the date of accident, Petitioner was **37** years of age, ***single*** with **5** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**.

Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $322.33 per week for 18-6/7 weeks, commencing 8/11/12 through 12/20/12, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 6/22/11 through 12/20/12, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services of $272.00, as provided in Sections 8(a) and 8.2 of the Act.

Petitioner is entitled to prospective medical treatment in the form of further NCV/EMG and/or PSSD testing to confirm/refute his diagnosis of post-traumatic neuritis or nerve compression/injury, a four week course of physical therapy concentrating in nerve desensitization, TENS, iontophoresis and strengthening of the left lower extremity, as well as medication and follow up visits to the Elmhurst Pain Clinic for pain management. Respondent shall pay the reasonable and necessary medical costs associated with said treatment, as provided in Sections 8(a) and 8.2 of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

3/11/13
Date

ICArbDec19(b)

STATEMENT OF FACTS:

Petitioner, a 37 year old certified nurse's aide (CNA), testified that she began working for Respondent in August, 2010. She had no problems with her left foot when she began the job. The only injury she could recall to her left foot was cutting a toe on that foot when she was four years old. She indicated that she felt great before beginning work on June 21, 2011.

On June 21, 2011 she was injured when a bed pump fell on her left foot. The pump weights about 50 lbs. She had pain in her left foot from the top to her toes. She informed the charge nurse, Christine. She was sent to the office where she took a drug test and filled out an incident report. Petitioner was sent to CHD, an urgent care center. The records from that facility dated June 21, 2011 indicate a history of pain in the left foot after a bed pump had fallen upon it. Petitioner was diagnosed with a contusion to the 2nd and 3rd toes of the foot and released to perform light duty. Petitioner testified that she was given medication and a special shoe. She continued to follow up at CHD for five weeks and continued to work light duty. Petitioner testified that she mainly did desk duty and folded clothes.

Petitioner testified that the doctors at CHD referred her to Dr. Witkowski at Orthopaedics of DuPage. Petitioner testified that she was still on light duty and noticed pain and tingling in the foot that was worse if she stood or sat too long. Dr. Witkowski first saw Petitioner on August 1, 2011. He continued the light duty status. On September 12, 2011 he noted that Petitioner had improved but still had swelling in her foot at the end of the day when she was active. She was diagnosed with mononeuritis and told to continue physical therapy and medication. The doctor was considering making a referral for injections to the foot. On October 13, 2011 Dr. Witkowski referred Petitioner to the Elmhurst Pain Clinic for a crush injury to the left 2nd and 3rd toes with radiating pain, burning and numbness. He felt she likely had an early complex regional pain syndrome.

Respondent had Petitioner evaluated by Dr. George Holmes on November 16, 2011. Dr. Holmes felt that Petitioner may have a Lisfranc injury and some mild neuritis. He recommended an MRI, bone scan and EMG. The doctors at the Elmhurst Pain Clinic noted on January 4, 2012 that Petitioner had a bone scan that was normal in the left foot. They, too, recommended an EMG.

Dr. Holmes wrote an addendum report on February 23, 2012 after reviewing additional records. He did not perform an additional examination. Dr. Holmes reviewed an MRI of January 16, 2012 that was normal. He reviewed an EMG dated February 2, 2012 that indicated evidence of mild healing injury to the left superficial peroneal sensory nerve. Dr. Holmes wrote that this was consistent with the symptoms and the exam. He also reviewed a negative bone scan. Dr. Holmes felt that Petitioner could return to her normal work with some symptoms. He went on to write that it would be helpful to get a Functional Capacities Evaluation if Petitioner's work capacity could not be determined.

The doctors at Elmhurst Pain Clinic, aware of the same testing continued to authorize light duty. Petitioner was last seen on August 29, 2012 and told to continue light duty.

Petitioner testified that in August of 2012 she was no longer provided light duty by Respondent. She stated that the cessation of her light duty job at that time was not her choice and that she is still willing to work light duty if it were available. Petitioner also indicated that she has not received any benefits since she has been off work. She testified that she was still feeling the same shooting pain at she stopped working, and that if she did too much walking her foot would swell. In addition, she indicated that she would experience numbness, tingling and sweating of her foot. Likewise, Petitioner noted that walking up and down stairs results in increased pain in her foot. She also indicated that she currently wears Crocs or moccasins, like the ones she was wearing at

arbitration. She stated that she had tried wearing heels and gym shoes but that she experiences a sharp pain if the shoe goes over her foot.

In the fall of 2012 Petitioner saw a podiatrist, Dr. Dukarevich. The first visit was September 7, 2012. He was aware of Petitioner's care at Elmhurst. He diagnosed post traumatic neuritis and type 1 complex regional pain syndrome. He felt the symptoms were mostly neuralgic. He suspected damage to the intermediate dorsal cutaneous and peroneal nerve on the dorsum. He authorized Petitioner off of work. Petitioner had a follow up visit on December 8, 2011. He noted a positive tinel sign over the tibial nerve at the tarsal tunnel. He recommended a repeat EMG, physical therapy, TNS and follow up at the Elmhurst Pain Clinic.

Respondent obtained an additional opinion from Dr. Holmes on November 19, 2012. Dr. Holmes, who had not seen Petitioner for a year, reviewed records and did not see the patient at that time. Dr. Holmes felt that Petitioner did not have complex regional pain syndrome. He offered no opinion as regards Petitioner's nerve injury. He also offered no further opinion regarding Petitioner's ability to work.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent does not dispute that Petitioner sustained accidental injuries arising out of and in the course of her employment on June 21, 2011 or that her current condition of ill-being is causally related to said accident. (See Arb.Ex.#1). Instead, Respondent disputes Petitioner's entitlement to medical expenses incurred at Elmhurst Pain Clinic totaling $272.00 (PX4), prospective medical treatment (issue "K", infra) and/or temporary total disability benefits (issue "L", infra). More to the point, Respondent relies on the opinion of it's §12 examining physician, Dr. George Holmes, to the effect that Petitioner had reached maximum medical improvement with respect to her injury and is not entitled to benefits subsequent to Dr. Holmes' report dated February 23, 2012.

Dr. Holmes examined Petitioner on one occasion. On that date, November 16, 2011, Dr. Holmes diagnosed a possible fracture of the metatarsal which he noted "could be the underlying cause of her continued pain. The patient may also have a Lisfranc injury and may have some mild neuritis over the dorsal aspect of the foot." (RX1). Dr. Holmes went on to note that "[a]t this point, I would recommend that she undergo an MRI scan, bone scan, and EMG to clearly delineate the presence or absence of nerve injury and/or the presence or absence of a contusion versus fracture versus Lisfranc fracture or dislocation." (RX1). Dr. Holmes estimated that he hoped that Petitioner would be at MMI in three to six months but noted that he would have a firmer idea along these lines once he had an opportunity to review the results of the aforementioned bone scan, MRI and EMG. (RX1). He also noted that Petitioner could continue to work light duty at that time. (RX1). Finally, Dr. Holmes opined that "[t]here does appear to be a causal connection between the work incident of 06/21/2011, and her current condition ongoing complaints." (RX1). Dr. Holmes also noted that he found "... no evidence of any malingering or prescription abuse ..." on that date. (RX1).

In a report dated February 23, 2012, Dr. Holmes noted that he had reviewed the requested test results, noting that the MRI of the left foot performed on January 16, 2012 revealed no obvious abnormality, that the EMG performed on February 2, 2012 was interpreted as evidencing a mild healing injury to the left superficial peroneal sensory nerve consistent with her symptoms and exam, and that the triple-phase bone scan failed to demonstrate any focal areas of increased uptake in relation to the bony structures of the

feet, and did not show any abnormality in the left midfoot area or any evidence of bone fracture healing. (RX2). Dr. Holmes noted that "[t]he studies, at this point, demonstrate no underlying structural damage to the foot per se. This EMG demonstrates some healing and involvement of the superficial peroneal nerve. This finding should have no significant functional impact on the patient other than her symptomatology as already outlined." (RX2). Dr. Holmes recommended continued use of "... the Lidoderm patch as well as desensitization techniques with regard to her ongoing symptoms. She may wish to continue her gabapentin as well." (RX2). Dr. Holmes went to opine that "[i]n terms of functionality, she should be able to probably return to many of her activities consistent with that of a CNA. She should not require any specific restrictions in terms of balancing or standing per se. Therefore, I think she should be able to return to her usual and customary duties, albeit with some underlying symptomatology." (RX2). Dr. Holmes concluded that if Petitioner was unwilling or unable to return to work as a CNA that "I think it would be helpful to get an FCE and have her return to some work in the medical field within the parameters of her FCE." (RX2). Finally, Dr. Holmes indicated that he believed Petitioner was "... functionally at an MMI status ..." and that "... subjectively, she will continue to improve over the ensuing months and should be subjectively at MMI status which should be consistent with her previous employment as a CNA at one year out from her injury of June 2011. Therefore, for clarification, I think she can return to her job as a CNA at this time, even though we will acknowledge that she does have some symptomatology still present. I do not believe she has any functional deficits at this time that would preclude her usual and customary duties." (RX2).

In his most recent report dated November 19, 2012, following his review of additional records, Dr. Holmes opined that Petitioner "... is not suffering from chronic regional pain syndrome. This opinion is based upon the EMG results, the triple phase bone scan results, the MRI results, my physical examination conducted on November 16, 2011, the pain clinic report of 05/11/2011, the pain center report of 06/19/2012, and the actual physical examination conducted by Igor Dukarevich, DPM on 09/07/2012. The objective findings and all of those records are inconsistent with chronic regional pain syndrome." (RX3).

For his part, podiatrist Dr. Dukarevich noted, in a report dated September 7, 2012, that in his opinion "... her symptoms appear mostly neurological. The mechanism of injury explains the damage to the intermediate dorsal cutaneous and deep peroneal n. on the dorsum of the left foot, with likely fibrosis and entrapment. The symptoms from the tibial n. and common peroneal n. are more difficult to explain and may be due to a secondary more proximal compression (i.e. radiculopathy) or CRPS type 1." (PX5). Dr. Dukarevich recommended another NCV/EMG study to determine the locations of the nerve compression. (PX5). Dr. Dukarevich went on to state that he believed that Petitioner would benefit from a four week course of physical therapy concentrating on nerve desensitization, and that she should continue to follow up with Elmhurst Pain Clinic for pain management. (PX5). Furthermore, in the event Petitioner failed to show improvement, Dr. Dukarevich opined that Ms. Venson would benefit from local nerve steroid injection blocks. (PX5). In addition, Dr. Dukarevich indicated that if further intervention was needed he would consider PSSD testing and nerve decompression. (PX5). Finally, Dr. Dukarevich noted that due to her constant pain and difficulty sleeping he gave Petitioner a release from work note and instructed Ms. Venson to follow up in one month. (PX5). Dr. Dukarevich's assessment was post-traumatic neuritis and CRPS type 1. (PX5).

In a subsequent report dated December 8, 2012, Dr. Dukarevich noted that Petitioner had not begun physical therapy as recommended and that "... [s]he relates no improvement in her symptoms since the last visit. She still [complains of] tingling and shooting pain in her left foot. She rates the pain at 5/10 at best, 10/10 at worst..." (PX5). Dr. Dukarevich indicated that "[a] s I was not able to evaluate previous

X-rays, MRI, EMG, and other test results, my opinion is based solely on the patient's description of her symptoms and my physical exam." (PX5). Dr. Dukarevich went on to state that while "[t]he patient's subjective complaints are certainly consistent with a diagnosis of CRPS" he was unable to confirm this diagnosis on physical exam. (PX5). Dr. Dukarevich did opine, however, that "the patient's objective symptoms are consistent with post-traumatic neuritis or nerve compression/injury to the above mentioned nerves. Further NCV/EMG testing or PSSD testing will be helpful in confirming the diagnosis." (PX5). Once again, Dr. Dukarevich recommended four weeks of physical therapy, follow up at Elmhurst Pain Clinic and continued medications. (PX5). Dr. Dukarevich also gave Petitioner an off work note on that date. (PX5).

Petitioner testified that she is uninsured and does not have any income to pay for physical therapy, and that the last therapy treatment she had was in late 2011. Petitioner also noted that she was last seen at Elmhurst Pain Clinic in August of 2012. She indicated that her condition has not changed in the past six months.

Based on the above, and the record taken as a whole, including the Arbitrator's observation of the Petitioner, the Arbitrator finds that Petitioner's current condition of ill-being and ongoing need for treatment with respect to her left foot is causally related to the undisputed accident on June 21, 2011. Along these lines, it would appear that Petitioner continues to experience legitimate complaints relative to her injury, and that her condition has not yet reached a point of maximum medical improvement. Along these lines, the Arbitrator chooses to rely on the opinion of Dr. Dukarevich to the effect that Petitioner current symptoms, which he noted were consistent with post-traumatic neuritis or nerve compression/injury, necessitated additional therapy and further testing – at least so as to rule out any differential diagnosis, given that both physicians do not appear to believe Petitioner is suffering from CRPS. With all due respect to Dr. Holmes, the Arbitrator finds that this recommendation is not all that unreasonable under the circumstances, particularly in light of Dr. Holmes' own pronouncement that he noted "… no evidence of any malingering or prescription abuse …" during the course of his one and only examination. (RX1).

Therefore, under the circumstances, the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses in the amount of $272.00 pursuant to §8(a) and subject to the fee schedule provisions of §8.2 of the Act.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

As noted with respect to the issue of medical expenses (Issue "J", supra), the Arbitrator finds that Petitioner's current condition of ill-being and ongoing need for treatment with respect to her left foot is causally related to the undisputed accident on June 21, 2011. As such, the Arbitrator likewise finds Petitioner is entitled to prospective medical treatment in the form Dr. Dukarevich's recommendations – namely, further NCV/EMG and/or PSSD testing to confirm/refute his diagnosis of post-traumatic neuritis or nerve compression/injury, a four week course of physical therapy concentrating in nerve desensitization, TENS, iontophoresis and strengthening of the left lower extremity, as well as medication and follow up visits to the Elmhurst Pain Clinic for pain management – and that Respondent shall be liable for the reasonable and necessary medical expenses associated therewith pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner is requesting temporary total disability benefits from August 6, 2012 through December 20, 2012. (Arb.Ex.#1).

It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, *i.e.*, whether the claimant has reached maximum medical improvement. *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission*, 236 Ill.2d 132, 142, 337 Ill.Dec. 707, ___, 923 N.E.2d 266, 271 (2010). The fact that the employee is no longer receiving medical treatment or that he or she has the ability to do light work does not preclude a finding of temporary total disability. *Rambert*, 477 N.E.2d at 1370.

The record shows that Petitioner's last day of light duty work for Respondent was on August 10, 2012. (PX6).

The record also shows that Dr. Dukarevich took Petitioner completely off work following his examination on September 5, 2012 as well as on December 8, 2012. (PX5). And while Dr. Holmes expressed the opinion that Petitioner could return to work full duty, he also indicated that in the event Petitioner was unable or unwilling to return to work as a CNA that it "...would be helpful to get an FCE and have her return to some work in the medical field within the parameters of her FCE." (RX2). Petitioner has yet to be released to return to work by Dr. Dukarevich and has yet to undergo any such FCE.

Therefore, based on the above, and the record taken as a whole, including the Arbitrator's determination as to Petitioner's ongoing need for treatment (Issues "J" and "K", supra), the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from August 11, 2012 through the date of hearing, December 20, 2012, for a period of 18-6/7 weeks.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Boyle,

Petitioner,

vs. NO. 03 WC 59667

City of Chicago,

14IWCC0197

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, notice, permanent disability, temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 3, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

No bond is required for removal of this cause to the Circuit Court by Respondent.

14IWCC0197

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 1 2014
SJM/sj
o-2/13/2014
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BOYLE, JOHN
Employee/Petitioner

Case# **03WC059667**

141IWCC0197

CITY OF CHICAGO
Employer/Respondent

On 1/3/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2988 CUDA LAW OFFICES
ANTHONY CUDA
6525 W NORTH AVE SUITE 204
OAK PARK, IL 60302

0766 HENNESSY & ROACH PC
JOSEPH ZWICK
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
) ss. 14IWCC0197
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

John Boyle
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **03** WC **59667**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Chicago**, on **October 15, 2012 and November 5, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Credit for overpayment of TTD benefits; prior denial of Respondent's request to dismiss**

FINDINGS 14IWCC0197

On **April 7, 2003**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Certain of Petitioner's conditions of ill-being through October 14, 2003, are causally related to the accident.

In the year preceding the injury, Petitioner earned $**69,538.36**; the average weekly wage was $**1,337.28**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**24,325.76** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**24,325.46 (to be applied against permanency- see Decision)**.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

Based on the findings regarding causal connection, TTD and PPD contained in the Arbitrator's Decision, no benefits are awarded.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

1/3/13
Date

JAN 3 - 2013

FINDINGS OF FACT

Petitioner testified that he began working for the City of Chicago in 1997. His title was seasonal engineer. In 2003, Petitioner worked at the Reed Facility where he loaded and unloaded trucks. Petitioner testified that on 4/7/03, Petitioner was working with a loader when he fell off the high lift. Petitioner testified that he slipped and fell backward approximately 8 or 9 feet down to the pavement. Petitioner testified that while on the ground he noticed that he was shaking, gasping for air and that he had pain and numbness throughout his body. He further testified that he had pain in his lower back and both feet with more pain on the left side than on the right. He also testified that he had headaches, blurred vision and that he hyperventilated for over an hour. Petitioner denied any prior problems with his neck, vision, spinal cord, right shoulder or left elbow, or any numbness tingling in left arm or left leg.

Petitioner was transported to Resurrection Hospital. On 4/7/03, Petitioner reported falling 6 to 7 feet onto concrete, landing on his left side and experiencing numbness and a heavy feeling and tightening in his left leg, left arm and right arm weakness without loss of consciousness or head contusion. The admitting diagnosis was left sided weakness, spinal cord contusion. Petitioner was evaluated by a neurologist, Dr. Koveleski, who determined that Petitioner had a spinal cord contusion. Dr. Koveleski also noted a chronic visual deficit in the right eye but that Petitioner's visual fields were full and he demonstrated full ocular motion. PX 1.

Petitioner was admitted to the intensive care unit where he stayed for 4 days and was treated with steroids. PX 1. Petitioner was diagnosed with a spinal cord contusion, incomplete cervical myelopathy with associated left-sided weakness and hemisensory loss, soft tissue injuries involving the left neck and shoulder, right adductor muscles, and contusion to the left elbow. PX 1. Petitioner was recommended continued steroids, physical and occupational therapy. Petitioner Petitioner attended therapy through 4/15/03 and was then released as of 4/21/03 with a final diagnosis of incomplete myelopathy, cervical spinal cord contusion, left sided weakness 4/5, left hemi-sensory loss from C3 and distal, soft tissue injuries to the left neck, shoulder, right abductor muscle, contusion of the left elbow and resulting deficits in mobility and self care. PX 1.

Respondent began making TTD payments to Petitioner as of 4/8/03.

Petitioner followed up with Dr. Koveleski on 5/15/03 after completing physical therapy. Dr. Koveleski noted some improvement in Petitioner's gait, with continued neck discomfort and into the trapezial area although foraminal compression was negative. Petitioner demonstrated 4/5 weakness in the left upper extremity and significant improvement in the left lower extremity. Dr. Koveleski determined that Petitioner was not yet able to return to heavy labor and continued Petitioner off work. He continued therapy and eventual work hardening. As of August 7, 2003, Petitioner subjective complaints of residual heaviness in his left upper extremity and left lower extremity continued as did complaints of discomfort and heaviness in both hands. Petitioner's neurosurgeon, Dr. Gutierrez recommended work hardening and Dr. Koveleski noted that he expected Petitioner to show more improvement at the time of the visit given a lack of findings on objective testing. A subsequently ordered EMG on the left upper and lower extremities was normal. As of October 1, 2003, Dr. Koveleski recommended 30 more days of work hardening as Petitioner could not yet lift over 55 pounds.

As of his visit with Dr. Koveleski on 11/13/03, Petitioner complained of worsening headaches although an MRI was unremarkable. Petitioner also complained of "worsening difficulty with his right eye" and was sent to Dr. Stiles for an ophthalmological evaluation. Dr. Koveleski kept Petitioner off work. Petitioner's final visit with Dr. Koveleski was on 1/22/04. At that time, Petitioner complained of additional right eye problems in the form of a "spider" movement across his field of vision. HE also complained of difficulty with heavy lifting and cold weather effects to his ears as well as hearing loss since the accident. Cold weather also aggravated the tingling in Petitioner's left hand and left foot. A repeat MRI showed no evidence of any intracranial pathology to support an additional cause for Petitioner's headaches and no change from the brain MRI of 4/8/03. Petitioner was seen by ophthalmologist Dr. McClennan on 12/18/03 who determined that Petitioner demonstrated an afferent pupillary defect and mild optic atrophy on the right eye but did suggest in his report that these findings are not recent, although it is impossible to tell when they first appeared and that it was possible the fall could have led to these findings. PX 6. Petitioner reported that his right eye vision was always weaker than his left eye but that he noticed it more since failing a driver's exam vision test at that time.

Petitioner was treated by Dr. Karnezis for a left elbow sprain and a right hand middle finger small fracture at the PIP joint. Both injuries healed well as of May 7, 2003. PX 3.

As of July 31, 2003, Petitioner's neurosurgeon, Dr. Gutierrez opined that Petitioner start work hardening as he had no abnormalities on neurological exam and "entirely normal" MRI examination of the cervical spine. He also ordered the August 2003 EMG of the left upper and lower extremities and back which Dr. Koveleski performed with normal results. PX4. Dr. Sobczak performed an SSEP study on 9/17/03 which reflects the impression of sensory nerve conduction time within normal limits of both lower extremities after stimulation of the left and right posterior tibial nerves. He noted there was prolongation of the peripheral latencies bilaterally, more on the left, for which clinical correlation was suggested.

The Mercy Works records at PX 5 show that Petitioner was released to full duty as of 10/15/03 with a notation of "based on job description of 50 lb limit". Based on a review of Petitioner's medical records as well as the May 2003 FCE and final work hardening reports, the Concentra nurse case manager drafted a closing report indicating that Petitioner could return to work full duty for Respondent with a 50 pound weight limit "that still meets his job requirements to return to work." Respondent was able to accommodate the work restrictions within his job description. RX 3. Petitioner testified that he returned to work for a short period working with a helper. He was subsequently laid off based on seniority. Petitioner returned back to work as of April 1, 2004 when he was brought back from lay off.

RX 5 is a Grand Jury indictment against Petitioner (and other defendants) for his participation in the City's Hired Truck Program scandal specifically during the years 2000 into 2004. The indictment describes activities in which Petitioner was illegally collecting fees in connection with the Hired Truck Program. Petitioner testified that he continued these collection activities in 2003 but is not sure for how long he continued the activity.

Petitioner pled guilty to Counts Two and Twenty-two of the Indictment for mail fraud and filing a false 2002 tax return. RX 6. Petitioner served time in federal prison from September 27, 2005 through July 7, 2010 based on his participation in the Hired Truck Program scheme. While in prison in Minnesota, Petitioner sought and received medical care for his diabetic condition. Petitioner was also treated for

cholesterol issues. In December 2006, additional studies of the right wrist, right 5th finger and cervical spine were negative for any findings. PX 8. Petitioner testified that he was able to leave the minimum security prison accompanied by another inmate for medical visits.

On 10/14/08, Petitioner saw an Ophthalmologist for complaints of "very poor vision in the right eye since an injury in 2003." The doctor noted, "He fell off a lift at that time, and presumably had traumatic optic neuropathy. He has noted a decrease in his vision for the last few months where everything has become more blurry. There is nothing that makes this better or worse and he has no associated symptoms." Upon exam, the assessment was "1. Probable TON (traumatic optic neuropathy) with optic atrophy OD, 2. Traumatic cataract OD- PAM showed 20/100 in the right eye- pt would like to pursue CE- I did state that the definite outcome is unknown. 3. Cupping – OD probably due to trauma, but will take photos today to monitor for glaucoma." The doctor continues, "After examination cataract surgery was recommended for the right eye. … Risks… were explained and patient elected to proceed with cataract extraction." The records document a lack of vision in Petitioner's right eye. Prison administration denied Petitioner's request for surgery and ordered a new examination in April 2009 before the surgery could be performed. It was ultimately determined that Petitioner did not meet prison criteria for the surgery and it was not performed. PX 8.

On March 12, 2012, Respondent had Petitioner examined by ophthalmologist, Dr. Golden-Brenner. Dr. Golden-Brenner also reviewed pertinent medical records concerning Petitioner's eye complaints and treatment since the accident including the Minnesota Federal Prison records of care. Dr. Golden-Brenner concluded that Petitioner suffered no direct ocular or direct or indirect head trauma in the accident of 2003 based on the medical records indicating the same. Therefore, she opined that any conditions linked to direct ocular trauma are not related to the accident. Further she noted that Petitioner's cataract was not secondary to the accident.

Dr. Golden-Brenner also noted that Petitioner's right eye was always weaker than his left and that he had chronic visual deficit in the right eye as documented in the treating records. She determined that the "marked difference in refraction between the eyes with the right eye being significantly more myopic is consistent with anisometropic amblyopia… which develops when the prescription in one eye is significantly different from the other causing chronic blurred vision in that eye." She determined the condition was neither caused nor aggravated by the accident. Further Dr. Golden-Brenner opined that amblyopia does not cause optic atrophy. Optic atrophy may occur from direct ocular trauma or severe head trauma. Again, since Petitioner suffered neither trauma, Dr. Golden-Brenner opined that the optic atrophy was not secondary to the accident. RX 2.

On July 19, 2011, Respondent had Petitioner examined by Dr. Gleason. Dr. Gleason also reviewed prior diagnostic testing summarized above and Petitioner's treatment records. Dr. Gleason's diagnosis was "findings as reflected on the diagnostic studies and mild weakness of the right fifth digit adductor." Dr. Gleason determined that Petitioner was capable of full time regular work without restrictions. He encouraged a home exercise program and determined no need for further treatment. RX 1.

At trial, Petitioner testified that he currently experiences sensations in his left foot and his headaches worsen with cold weather. Petitioner complained of continued low back pain and occasional swelling of his hands. He has no vision in his right eye.

CONCLUSIONS OF LAW

C. Did an accident occur which arose out of and in the course of Petitioner's employment by Respondent? E. Was timely notice of the accident given Respondent?

Petitioner testified that he slipped from a high-lift and fell approximately eight to nine feet. The initial medical records as well as the following up treatment records contain consistent histories of Petitioner falling between six and seven feet from a high lift at work on 4/7/03. Petitioner asserts that his supervisor was present on the date of his accident and initial records indicate that Petitioner provided a consistent report to the Concentra nurse case manager while at the hospital. Accordingly, the Arbitrator finds that Petitioner did suffer an accident on April 7, 2003 and further finds that Petitioner provided timely notice regarding the same.

F. Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner alleges several conditions and offers several complaints in connection with this matter. It is noted that Petitioner was diagnosed with a spinal contusion while hospitalized in Resurrection Medical Center. The initial complaints refer to left-sided upper and lower extremity weakness and difficulty in connection with the same. Petitioner was also treated for a left elbow sprain and a right hand middle finger small fracture at the PIP joint. Petitioner is also blind in the right eye and has a right eye cataract.

Based on the records as summarized above, the Arbitrator finds causal connection for Petitioner's spinal contusion as reflected in the medical records and for his elbow sprain and right middle finger fracture. In so finding, the Arbitrator notes there is nothing in the record to suggest that Petitioner suffered left sided upper and lower extremity weakness and difficulty or any problems with his left elbow or right middle finger prior to this accident. After the accident, Petitioner's symptoms were immediate and acute. The Arbitrator further finds that Petitioner was treated for these conditions in the hospital and at follow up with his treating physicians through October 14, 2003. The Arbitrator finds casual connection for these conditions through October 14, 2003, the date before Petitioner's release to full duty work for Respondent. Petitioner's release to work followed normal findings on several objective tests as well as the successful completion of an FCE and work hardening. Finally, the Arbitrator notes that subsequent to October 15, 2003, the record is devoid of any objective evidence to support Petitioner's subjective continued complaints.

The Arbitrator further finds no causal connection between Petitioner's right eye conditions of cataract and blindness and the accident of 4/7/03. In so finding, the Arbitrator notes that Petitioner did not suffer acute head or eye trauma in the fall. Petitioner specifically denied any initial head injury and did not initially report complaints involving the right eye. When Petitioner did begin reporting symptoms with regard to the right eye, he noted that his right eye had always been weaker than the left. The Arbitrator's finding of no causal connection is further based on the more credible and thorough opinion of Dr. Golden-Brenner rather than on the speculative statements of Dr. McClennan or the prison examining doctor regarding the connection between Petitioner's fall and his right eye condition.

K. What temporary benefits are in dispute? TTD O. Does Respondent receive credit for overpayment of TTD benefits?

Petitioner requests temporary total disability for a period of 38-1/7 weeks commencing 4/8/03 through 3/31/04, the day before his return to full duty work from lay off. However, the Arbitrator notes the above finding of causal connection for Petitioner's spinal cord contusion injury through 10/14/03, the day of Petitioner's release to return to work by Mercy Works. Accordingly, the Arbitrator finds that Petitioner was not temporarily and totally disabled subsequent to 10/15/03.

With regard to the period of alleged TTD commencing 4/8/03 through 10/14/03, the Arbitrator notes Respondent paid TTD benefits to Petitioner commencing 4/8/03 through 10/14/03 totaling $24,325.76. ARB EX 1. However, the Arbitrator notes that the Federal Indictment clearly indicates that in 2003 Petitioner was engaged in ongoing income earning activities connected to his involvement with the City's Hired Truck Program. RX 5. The activity demonstrated that Petitioner was capable of, and in fact did, earn an income while he received TTD benefits. As such, the Arbitrator finds that Petitioner was not entitled to TTD benefits during this period and Respondent shall be provided a credit of $24,325.76 to be applied towards permanency. Utilizing Petitioner's PPD rate of $542.17, this would equate to 44.87 weeks of permanency.

L. What is the nature and extent of the injury?

The Arbitrator notes that Petitioner bears the burden of proving all elements of his claim by a preponderance of the credible evidence submitted. The Arbitrator found that Petitioner sustained a fall at work on 4/7/03 followed by medical treatment for the causally related spinal contusion, elbow and finger injuries. Following his discharge, Dr. Gutierrez noted that Petitioner's recovery was moving along well. The ongoing MRI scans and EMG tests performed revealed no objective basis for any ongoing complaints subsequent to July 2003. Petitioner was done treating for his elbow and wrist injuries as of May 2003. Petitioner had minimal complaints of any current problems at trial. Based upon the evidence as a whole, the Arbitrator finds that Petitioner fully recovered from the causally related injuries received in the fall of 4/7/03. Furthermore, any finding of minimal permanency for loss of use of a man as a whole would be negated by the application of Respondent's credit for overpayment of TTD benefits. As such, no award for permanency is made.

O. Other – the propriety of the prior Arbitrator's denial of Respondent's prior request to dismiss

Lastly, the Arbitrator notes Respondent preserved an issue at trial regarding the propriety of the Arbitrator's denial of its motion to dismiss this matter while Petitioner was in prison. The Arbitrator finds that issue to be moot in light of the foregoing findings.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Edith Herman Lopez,

Petitioner,

vs.

NO: 12WC 31689

Metropolitan Bank Group,

14IWCC0198

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical, temporary total disability, permanent partial disability, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 28, 2013, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

14IWCC0198

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 2 4 2014

o031914
CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

LOPEZ, EDITH HERMAN
Employee/Petitioner

Case# **12WC031689**

14IWCC0198

METROPOLITAN BANK GROUP
Employer/Respondent

On 2/28/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

2662 LAW OFFICES OF JAMES J BURKE LTD
333 N MICHIGAN AVENUE
SUITE 1126
CHICAGO, IL 60601-3759

0766 HENNESSY & ROACH PC
GUY E DITURI
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

☐	Injured Workers' Benefit Fund (§4(d))
☐	Rate Adjustment Fund (§8(g)
☐	Second Injury Fund (§8(e)18)
☒	None of the above

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

EDITH HERMAN LOPEZ
Employee/Petitioner

Case #12 WC 31689

v.

14IWCC0198

METROPOLITAN BANK GROUP
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on February 15, 2013. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☐ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☐ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On May 30, 2012, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $73,782.80; the average weekly wage was $1,418.90.
- At the time of injury, the petitioner was 46 years of age, *married* with one child under 18.
- The parties agreed that the respondent paid $21,081.00 in temporary total disability benefits.
- The parties agreed that the respondent paid all the related medical services provided to the petitioner.

ORDER:

- The petitioner's request for benefits for a work injury to her cervical spine on May 30, 2012, is denied.
- In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, medical benefits, or compensation for a permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert E. Williams
Robert Williams

2/27/13
Date

FEB 28 2013

FINDINGS OF FACTS:

The petitioner, a manager of two bank branches, received physical therapy at Mercy Hospital and Medical Center on May 23, 2012, for left her low back and reported moving her branch and getting some spasms at night that was relieved with medications. She saw Dr. Slack on May 24, 2012, for treatment of her degenerative disc and facet disease. At the next therapy session for her low back on May 31st, she reported moderate-severe pain because of weather and lifting/carrying at work. She reported low back stiffness at therapy on June 7th and moderate back pain on the 8th. She reported pneumonia-like feeling to the therapist on June 13th and then sought care at the Mercy Hospital and Medical Center emergency department and reported left back and chest pain, left arm pain and heaviness and the inability to take deep breaths for one to two days that was exacerbated by exertion. It was noted that her neck was supple. At the therapy session on June 20th, she reported upper back symptoms she attributed to throwing grandkids into a pool.

Dr. Garcelon of Mercy Hospital and Medical Center saw the petitioner on June 22nd and noted that the petitioner reported searing left upper back pain starting two weeks earlier. Pursuant to a request from Dr. Garcelon, an MRI of her cervical spine on June 28th revealed mild spondylosis at C5-6 and C6-7 and osteophytes encroaching on the neural foramina. Dr. Slack saw the petitioner on July 19th and noted complaints of sharp, hot, searing, knife-like neck pain down into her left, medial scapula. The doctor noted a limited range of motion due to neck pain. On August 2nd, the petitioner reported to Dr. Slack that on May 30th she started having increasing symptoms. On September 6th, the petitioner reported some relief of burning-type pain from a cervical epidural injection but

persistent neck and pain across her shoulders. She started physical therapy and received two more cervical epidural injections. The petitioner reported continuing neck symptoms on February 1, 2013, and Dr. Slack recommended an evaluation by Dr. Ted Fisher.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that her current condition of ill-being with her cervical spine is causally related to a work injury on May 30, 2012. She had several physical therapy sessions from May 30, 2012, and only reported low back pain through June 20th. At that time, she reported upper back symptoms that she attributed to throwing her grandkids into a pool. And when the petitioner saw Dr. Garcelon on June 22nd, and she only reported upper back pain that began two weeks earlier. The evidence does not support any symptoms or complaints of neck pain contemporaneously with May 30, 2012. The petitioner is not credible or believable. The opinion of Dr. Slack is not consistent with the evidence and is conjecture. Her request for benefits for a work injury to her cervical spine on May 30, 2012, is denied.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that she is entitled to temporary total disability benefits.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner failed to prove that an evaluation by Dr. Fisher recommended by Dr. Slack is reasonable medical care necessary to relieve the effects of a work injury on May 30, 2012.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shawn Heuer,

Petitioner,

vs.

NO: 10 WC 23494

Menard Correctional Center,

Respondent,

14IWCC0199

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of permanency and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Arbitrator's award, reducing the loss of use of the left arm to 15%. All else is affirmed.

The Petitioner testified on July 22, 2013, that he had a lot of pain in his left elbow and that it was numb. He testified that Dr. Brown advised him on May 21, 2013, that eventually those symptoms would go away.

According to the notes of Dr. Brown on May 21, 2013, Petitioner indicated that the numbness and tingling in both hands is decreased. Petitioner noted a bump over the posterior aspect of his left elbow but the Doctor pointed out that that was the olecranon process and that there was a similar bump over the posterior aspect of his right elbow. "I explained to Shawn this is a normal anatomical structure. I see nothing here that is out of the ordinary." The Doctor indicated that Petitioner had done very well and that he had no specific recommendations at this time. Petitioner was released to full duty with no restrictions. (Petitioner Exhibit 1)

14IWCC0199

The Petitioner testified that the Doctor's statement, that the pain and numbness would eventually go away, was made 2 months before he testified at the Commission. This was not enough time for the Doctor's opinion to come to fruition.

The Commission finds that Petitioner has a 15% loss of use of the left arm as a result of this injury.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE that Respondent pay to Petitioner the sum of $612.92 per week for a period of 75.9 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 15% of the right arm and 15% of the left arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

DATED: MAR 2 4 2014

CJD/hsf
022014
049

Charles J. DeVriendt

Stephen Mathis

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HEUER, SHAWN
Employee/Petitioner

Case# **10WC023494**

SOI/MENARD CORRECTIONAL CENTER
Employer/Respondent

14IWCC0199

On 8/22/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4852 FISHER KERHOVER & COFFEY
JASON E COFFEY
P O BOX 191
CHESTER, IL 62233

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PKWY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0558 ASSISTANT ATTORNEY GENERAL
KENTON J OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST
13TH FLOOR
CHICAGO, IL 60601-3227

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

AUG 22 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0199

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Shawn Heuer
Employee/Petitioner

v.

State of Illinois/Menard Correctional Center
Employer/Respondent

Case # 10 WC 23494

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on July 22, 2013. By stipulation, the parties agree:

On the date of accident (manifestation), June 4, 2010, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned $53,120.00, and the average weekly wage was $1,021.54.

At the time of injury, Petitioner was 39 years of age, single with 2 dependent child(ren).

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00. The parties stipulated that all TTD had been paid.

After reviewing all of the evidence presented, the Arbitrator makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of $612.92 per week for 88.55 weeks because the injury sustained caused the 20% loss of use of the left arm and 15% loss of use of the right arm, as provided in Section 8(e) of the Act.

RULES REGARDING APPEALS UNLESS a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE IF the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

William R. Gallagher, Arbitrator

Augusut 18, 2013
Date

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent. The Application alleged a date of accident (manifestation) of June 4, 2010, and that Petitioner sustained repetitive stress/trauma to his right and left elbows. There was no dispute regarding compensability and the parties stipulated that temporary total disability benefits and medical had been paid by Respondent. Accordingly, the only disputed issue at trial was the nature and extent of disability.

Petitioner worked for Respondent as a Correctional Officer and, as a result of his job duties, sustained repetitive trauma injury to both arms/elbows. On June 2, 2010, Petitioner was seen by Dr. David Brown, an orthopedic surgeon. Dr. Brown examined Petitioner and opined that the symptoms and findings were consistent with ulnar neuropathy. Dr. Brown referred Petitioner to Dr. Dan Phillips who performed nerve conduction studies that same day which were positive for bilateral cubital tunnel syndrome. Dr. Brown opined that Petitioner's condition was related to his work as a Correctional Officer.

Dr. Brown initially attempted conservative treatment with elbow splints; however, Petitioner's condition did not improve. When Dr. Brown saw Petitioner on August 4, 2010, he recommended that Petitioner undergo surgeries on both elbows; however, he did authorize Petitioner to continue to work with no restrictions up until the time of surgery.

Petitioner changed jobs in March, 2011, and began working for Menard Farm Industries, where he was employed as a truck driver. Petitioner would still use Folger-Adams keys; however, he no longer was required to perform many of the job duties that he previously performed as a Correctional Officer such as bar rapping, opening/closing cell doors, crank operating, etc.

Dr. Brown did not see Petitioner again until January 21, 2013, and, at that time, he renewed his recommendation that Petitioner undergo elbow surgeries. Dr. Brown performed ulnar decompression and transposition surgeries on the right and left elbows on March 15 and April 5, 2013, respectively. Subsequent to the surgeries, Petitioner had physical therapy. When Dr. Brown saw Petitioner on May 21, 2013, Petitioner advised that the numbness/tingling had decreased in both hands but that he still noticed a "bump" over the posterior aspect of the left elbow. Dr. Brown's findings on examination were benign and he released Petitioner to return to work without restrictions.

At trial, Petitioner testified that he still has symptoms of pain and sensitivity in both elbows; however, he has substantially more complaints in regard to the left elbow. Petitioner described the pain in the left elbow as being "constant," that it frequently becomes numb and that he experiences what he describes as "Charlie horses" of the muscles in the left forearm. In regard to his right elbow, Petitioner's symptoms were considerably less and, on cross-examination, Petitioner admitted that on April 26, 2013, Petitioner informed the physical therapist that his right elbow felt "perfect" but that his left elbow continued to be sore and weak.

Conclusions of Law

The Arbitrator concludes that Petitioner sustained 20% loss of use of the left arm and 15% loss of use of the right arm.

In support of this conclusion the Arbitrator notes the following:

Petitioner was diagnosed with bilateral cubital tunnel syndrome and ulnar transposition surgeries were performed on both elbows. The Petitioner still has symptoms in regard to both elbows; however, Petitioner presently has more symptoms in respect to the left elbow than the right.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☒ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Vance Farace,
Petitioner,
vs.
AT & T,
Respondent,

NO: 10 WC 16783

14IWCC0200

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of the nature and extent of Petitioner's permanent disability, 8(f) and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 2, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAR 25 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
O:3/6/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FARACE, VANCE
Employee/Petitioner

Case# **10WC016783**

14IWCC0200

AT&T
Employer/Respondent

On 8/2/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1767 TUTAJ, JAMES P
3416 W ELM ST
McHENRY, IL 60050

0766 HENNESSY & ROACH PC
TOM FLAHERTY
140 S DEARBORN SUITE 700
CHICAGO, IL 60603

14IWCC0200

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [x] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [ ] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Vance Farace
Employee/Petitioner

v.

AT&T
Employer/Respondent

Case # 10 WC 16783

Consolidated cases: ___

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Waukegan** , on **June 20, 2013**. By stipulation, the parties agree:

On the date of accident, **January 29, 2010**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned $**69,405.96**, and the average weekly wage was $**1334.73**.

At the time of injury, Petitioner was **48** years of age, ***married*** with **1** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $**78,685.00** for TTD, $**n/a** for TPD, $**78,430.51** for maintenance, and $**n/a** for other benefits, for a total credit of $**157,115.51**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner permanent and total disability benefits of $**889.73**/week for life, commencing **June 21, 2013**, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund*** , as provided in Section 8(g) of the Act.

RULES REGARDING APPEALS Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Edward Lee
Signature of Arbitrator

7/31/13
Date

AUG 2 - 2013

PETITIONER'S PROPOSED FINDINGS

In support of the Arbitrator's decision relating to the Nature and Extent of Petitioner's injuries, the Arbitrator finds as follows:

There is no dispute that Petitioner is unable to return to his former occupation as a cable splicer with Respondent. All of the medical and vocational evidence entered into evidence establishes that Petitioner's current condition and medical restrictions preclude him from returning to his former job with Respondent.

Respondent has not offered Petitioner employment within the restrictions imposed by Petitioner's treating physicians nor has Respondent provided Petitioner with vocational rehabilitation and job placement services as contemplated by Section 8(a) and Section 7110.10 of the Rule Governing Procedure before the Illinois Worker's Compensation Commission. Respondent did not respond to Petitioner's demand for Vocational assistance and Petitioner was not provided any assistance with his self-directed job search.

Petitioner's Exhibit 3 is the Functional Capacity Evaluation performed on October 11, 2011. The Functional Capacity Evaluation was performed upon the recommendation and request of Respondent's independent medical examiner, Dr. Mirkovic (P. Ex. 2, Pg 14).

In regard to Petitioner's functional capacities, Mr. Honcharuk reports:

> "The results of this evaluation are considered valid as Mr. Farace passed the clinical and subjective tools utilized by this evaluator. Mr. Farace exhibited signs of full physical effort to the extent that he could given his foot drop and AFO. Mr. Farace is not capable of performing physical demands of the target job of "cable splicer"... ***Mr. Vance Farace safely performed at the less than sedentary physical demand level.***" *[emphasis added]* during the course of this evaluation. He was unable to safely push, pull, carry and lift to match the functional job descriptions. (P. Ex. 3, Pg 1)

Mr. Honcharuk reports that Petitioner is significantly limited in his ability to stand, walk, sit, lift, carry, push, pull, climb, stoop, crouch, crawl and perform low level work. Specially, in an 8 hour work day, Petitioner can stand for a total of less than 2 hours with a single longest duration of approximately 47 minutes. His walking is limited up to 5 minutes at a time. He can sit for a total of approximately 3 hours with a longest single duration of 35 minutes. He is limited to carrying 10 lbs. He is unable to lift any weight from the floor to a height of 31 inches, he is limited to 35 lbs between his waste and shoulder level, and unable to safely lift any weight above shoulder level. (P. Ex. 3, Pgs 31-32).

On March 23, 2012, Petitioner's attending Physical Medicine and Rehabilitation physician, Dr. Mary Norek of Orthopedic Associates of DuPage reports:

> "It is my medical opinion that the Functional Capacity Evaluation prepared through Athletico Physical Therapy on October 11, 2011 consisting of 36 pages was thorough and accurate. * * * The examining therapist did indicate that the test was valid and that full effort was put forth. If it provides any help to those requesting the information from me, I have reviewed the FCE. The data of interest, I believe is provided in the first 3 pages. To briefly summarize this, he tolerates standing for a total duration of 1 hour 45 mins in an 8 hour day, longest duration 47 minutes continuously. He tolerates walking for 5 minutes at a time. He tolerates sitting for 35 minutes at a time, total duration 2 hours 51 minutes in an 8 hour day. The only lifting that he tolerated was when lifting from 31 inches off the floor to 61 inches

with a maximum lifting tolerance of 30 lbs in this range of height. Lifting at other heights was not tolerated. He does not tolerate carrying as he is to walk with a cane and his AFO. Pushing and pulling also were not tolerated because of the use of his cane and AFO. He doesn't tolerate any climbing, stooping, crouching, crawling or low level work. He does tolerate reaching forward in the 31-61 inch height. He fine dexterity was normal. Please refer to the 36 page report for additional details. (P. Ex. 4, Pg 2).

Petitioner testified that Dr. Norek has not released him to return to any type of employment. Petitioner further testified that Dr. Norek is unwilling to modify any of his physical restrictions. Petitioner is still under the care and treatment of Dr. Norek. He last saw Dr. Norek approximately three weeks prior to the arbitration hearing. He is next scheduled to see her in December 2013. Dr. Norek monitors the atrophy in his left lower extremity, his drop foot, and reviews and renews his prescription medications.

On September 28, 2012, Dr. Norek reports that Petitioner was seen for follow up following adaptions to his AFO to allow blisters on his left foot and ankle to heal. Dr. Norek reports that Mr. Farace's is not a candidate for a hinged AFO at the ankle due to persistent quad muscle weakness.

Her physical examination revealed that Mr. Farace was walking with a cane and wearing his left AFO. His calloused blisters over the left distal achilles tendon and medial malus were decreased in size with no open lesions. The Petitioner had positive straight leg raise on the left at 45 degrees, significantly decreased muscle strength in the left quad, left hip flexors, ankle, extensor hallucis longus, and ankle evertors. Dr. Norek noted atrophy in the left calf causing poor fitting of the AFO brace. Her assessment included drop foot, lumbar radiculitis, and blister of the ankle without infection. She recommended continued home stretches and exercise.

Dr. Norek's office note reflects Petitioner was taking Naprosyn, Ambien, Zoloft, Prilosec, Lyrica and Norco (P. Ex. 4, Pgs 4-5).

Petitioner testified that he is now taking the maximum allowable dosage of Lyrica.

Petitioner's Exhibit 8 is the report of Petitioner's vocational rehabilitation counselor, Mr. Edward Steffan. Mr. Steffan's report indicates he was retained to conduct an initial vocational evaluation, transferrable skills analysis and a labor market sampling. (P. Ex. 8, Pg1). Mr. Steffan notes that Petitioner graduated high school in 1979, is a certified automobile mechanic, and has worked as a mechanic and cable splicing technician for AT&T since May 1992. Following his graduation from high school in 1979, he worked as an auto mechanic at auto dealerships prior to joining AT&T.

In regard to his transferrable skills analysis, Mr. Steffan reports that he identified 171 job titles, which, in general, Petitioner would have transferrable skills to perform. (P. Ex. 8, Pg 8) Some of the job titles identified by Mr. Steffan include glass grinder, trouble locator, solderer, lock assembler, assembler, semi-conductor microelectronics processor, laminator 1 and bench hand. *Id.* Mr. Steffan notes however that his transferrable skills analysis ***"identifies positions with limited availability in Mr. Farace's labor market area."*** [emphasis added] In addition, Mr. Steffan concludes that given Petitioner's physical restrictions and the physical demands of the positions identified by his transferable analysis "it is not reasonable to be of the opinion Mr. Farace could perform the essential job tasks of these jobs ***even if he were able to induce a potential employer to hire him over job applicants."*** [emphasis added] (P. Ex. 8, Pg 8). Mr. Steffan also reported on the results of his telephonic labor market sampling. He reports that 6 employers had 22 positions which may be commensurate with Petitioner's rehabilitation variables. However, only one employer had one position open and available at the time he conducted his labor market sampling.

Based upon his vocational evaluation, his transferable skills analysis and his labor market survey, Mr. Steffan concludes that Petitioner is not a candidate for vocational rehabilitation and that there is no readily available stable labor market for Petitioner:

> "There would appear to be no readily available stable labor market for Mr. Farace given his need to alternate between sitting, standing and walking as noted in the Functional Evaluation, Dr. Norek utilized to identify Mr. Farace's available physical capacities for work;
>
> It appears given Mr. Norek's release Mr. Farace may not be released to perform an 8 hour work day;
>
> Given this information, we do not recommend Mr. Farace be provided assistance by a certified rehabilitation counselor providing vocational placement assistance ***as it is not probable he could induce a potential employer to hire him over employment candidates.***" (P. Ex. 8, Pg 8).

Respondent's Exhibit 1 is the report of vocational assessment performed by Respondent's vocational counselor, Eric Flanagan dated March 25, 2013. Mr. Flanagan notes the results of the FCE dated October 11, 2011 and Dr. Norek's restrictions as noted in her March 23, 2012 progress note. Mr. Flanagan reports that Petitioner has been looking for work for approximately one year and that his job search is ongoing. Petitioner explained that he looks for jobs in local newspapers, on the internet, using such sites as Monster and Craigslist and inquires in person or by making phone calls. Mr. Flanagan's conclusion was that ***"Mr. Farace has a valid FCE outlining his physical capabilities, which are below a sedentary level."*** *[emphasis added]*, with very restricted capacities in the area of sitting. Mr. Farace has no experience in sedentary-based positions and uses a cane extensively to both sit and ambulate.'

Mr. Flanagan expresses no opinion in his report as to whether Mr. Farace is a viable candidate for vocational rehabilitation, or whether a readily stable labor market is available to Mr. Farace given his age, education, training and his restrictions.

Respondent's Exhibit 2 is a labor market survey prepared by Respondent's vocational rehabilitation consultant Encore Unlimited, dated June 14, 2013. The report identifies 12 employers which provided information about current openings for positions identified as potential alternate employment for Petitioner.

The report however, does not identify the physical requirement of any of the positions identified nor is there any information or data provided from which it can be concluded that the physical requirements of the identified positions are within Petitioner's limitations as identified by the FCE and Dr. Norek's restrictions.

The report concludes that Petitioner should be able to obtain employment within his restrictions if he is able to obtain reasonable accommodations.

Petitioner testified that he experiences some level of low back pain on a daily basis. He stated that he has no feeling in his leg below his knee and requires the use of an AFO brace and cane to walk. He has difficulty walking without the brace and cane and has fallen when he attempted to walk with the cane and brace. He confirmed that his left leg is atrophied and smaller than his right leg. He testified that he has difficulty sleeping, requires the use of prescription medications Norco and Lyrica on a daily basis to control his pain, and finds it necessary to lay down during the course of the day due to his back pain and the sedative effects of his prescription medications. He is able to cook for himself and perform light housework. He is limited in his ability to perform virtually every other activity.

Petitioner testified that he began looking for work following completion of the FCE in October 2011. He has not received any requests for interviews much less any job offers. He further testified that he contacted the employers identified in the labor market surveys prepared by Ed Steffan and Encore Unlimited and that no positions were available within his restrictions.
Petitioner's exhibit 7 is a sample of the job contacts and applications he submitted as part of his on line job search. Petitioner also brought with him a year's worth of classifieds from his local daily newspaper that reviewed as part of his job search.

The arbitrator notes that Petitioner's testimony was credible and consistent with the medical records and reports prepared by the respective vocational counselors.

The Arbitrator has also reviewed Respondent's exhibit 3, the surveillance video conducted of Petitioner on September 27 and 28, 2012. The Arbitrator notes that Petitioner's activities as reflected in the surveillance video are consistent with Petitioner's testimony, and his limitations and restrictions noted in his medical records and the FCE.

In *Ceco Corp. vs. Industrial Commission*, 95 IL2d 278, 286-87 (1983) the Supreme Court held that:

> An employee is totally and permanently disabled when he is unable to make some contribution to the work force sufficient to justify the payment of wages. The claimant need not, however, be reduced to total physical incapacity before permanent total disability award may be granted. Rather, a person is totally disabled when he is incapable of performing services except those for which there is no reasonable stable market.

If a claimant's disability is not so limited in nature that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, to be entitled to permanent disability benefits under the Act, the claimant has a burden of establishing the unavailability of employment to a person in his circumstances; that is to say that he falls into the "odd/lot" category. *Valley Mold & Iron Co. vs. Industrial Commission*, 84 IL2d 538, 546-47(1981); *A.M.T.C. of Illinois Inc. vs. Industrial Commission*, 77 IL2d 42, 490 (1979).

A claimant can satisfy his burden of proving that he falls into the "odd/lot" category by showing diligent but unsuccessful attempts to find work or by showing that he will not be regularly employed in a well-known branch of the labor market. *Westin Hotel vs. Industrial Commission*, 372IL3d 527, 544 (1st Dist. 2007).

In determining whether a claimant falls within an odd/lot category for purposes of an award of permanent disability benefits, the Commission should consider the extent of the claimant's injury, the nature of his employment, his age, experience, training, and capabilities. *A.M.T.C. of Illinois Inc. vs. Industrial Commission*, 77IL2d at 489.

The arbitrator finds that based upon the records of Petitioner's treating physician, Dr. Norek, the FCE dated October 11, 2011, the report of Petitioner's vocational counselor, Ed Steffan and Petitioner's credible testimony regarding his current condition and job search, Petitioner has met his burden of proving that he falls into the odd-lot category of permanent total disability. Petitioner has presented credible evidence that there is no reasonably stable labor market readily available to the Petitioner based upon his age, education, work experience, and most importantly his physical limitations and restrictions as identified by the FCE and Dr. Norek.

The findings of the FCE, Dr. Norek's restrictions and the results of her physical examinations, and Petitioner's testimony regarding his current condition and limitations, is uncontested and un-refuted. Of the reports of the two vocational consultants, the Arbitrator relies more heavily upon the report of Petitioner's vocational counselor, Ed Steffan. The Arbitrator notes that to a certain extent even the opinions set forth in Mr. Steffan's report are un-rebutted. The Respondent's vocational counselor never expresses the opinion that a stable labor market is readily available to Mr. Farace given his physical limitations and restrictions. Respondent's counselor acknowledges that Petitioner's physical restrictions place him at the less than sedentary physical demand level and he never identifies or credibly establishes that there is a reasonably stable labor market, much less any labor market, readily available for individuals who work at a less than sedentary physical demand level. Respondent's labor market survey identifies employment opportunities which match Petitioner's theoretical transferable skills, but there is no information or data which establishes, or from which the Arbitrator can reasonably infer, that the physical demands of the positions identified meet the Petitioner's restrictions, or correspond to a less than sedentary physical demand level. Respondent's opinion or contention that Petitioner is employable is conditioned upon an assumption that the employer will be willing to make reasonable accommodations for Petitioner. This is a far cry from concretely identifying employer who are willing to make reasonable accommodations and do have jobs readily available that Petitioner can safely perform.

Once a claimant initially establishes that he falls into the odd-lot category, the burden shifts to Respondent to show that some kind of suitable work is regularly and continuously available to the claimant. *Valley Mold & Iron Co.*, 84 IL2d at 547.

For the reasons noted above, the Arbitrator finds that Respondent has failed to establish, more probably true than not, that some kind of suitable work is regularly and continuously available to the Petitioner.

As noted, Respondent's vocational counselor does not dispute that Petitioner's restrictions place him at the less than sedentary physical demand level. Although their consultant identifies potential employment opportunities that match Petitioner's transferable skills, there is no indication that the duties of these potential jobs are within Petitioner's physical limitations. Moreover, Respondents vocational consultant never expressly states that a stable labor market is readily available to Petitioner given his less than sedentary job restrictions.

The Arbitrator finds Petitioner has met his burden for establishing an award for permanent total disability under the "odd-lot" theory. Therefore, the Arbitrator finds Petitioner to be permanently and totally disabled and awards him the sum of 889.73 per week for life as provided in Section 8(f) of the Illinois Workers Compensation Act. The Petitioner is entitled to receive such weekly benefits commencing June 21, 2013, the day after completion of the trial of this matter.